Pediatric Sports and Spine

Communication Consent (Circle Yes or No)

The doctors and staff at Pediatric Sports & Spine Associates may need to discuss and/or release your Protected Health Information (PHI) to:

You: Yes No **Specified other persons:** Yes No

If you checked yes to specified other persons, please list to whom your protected Health Information may be released.

Name **Phone** **Relationship to you**

_____

_____

_____

Protected Health Information may also be released: **(Circle Yes or No)**

Yes No - Left on my home voice mail (phone #)_____
Yes No - Left on my office/work voice mail (phone #) _____
Yes No - Mailed to my home at the address Provided below
Yes No - Discussed directly over the phone with me or a specified person Named above.
Yes No - Faxed to # _____

Yes No - emailed to_____
e-mail address

Address where PHI may be mailed:

_____
Street city State Zip code

What Information May be Released? (Circle Yes or No)

Yes No Lab Results
Yes No X-Ray/Diagnostic Reports
Yes No Medications
Yes No Medical Status
Yes No Appointments/Appointment Reminders
Yes No Other_____

I understand that as part of my continuing healthcare, my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that this document is part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I need to notify the physician in writing of these changes.

_____ _____ Date _____
Printed Patient Name Patient signature (Guardian if under age 18)