ORTHOPEDIC SPECIALISTS OF IDAHO

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PROTECTED HEALTH INFORMATION RELEASE

☐ You have my permission to speak with my spouse about my medical care.

☐ You have my permission to leave information on my answering machine regarding my medical care and test results

☐ You have my permission to talk with my children or other family members involved with my medical care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Other. Please describe: _____

_____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____