Dearborn Orthopedics & Sports Medicine, PC
23550 Park Street
Suite 100
Dearborn, MI 48124

PERMISSION TO GIVE MEDICAL INFORMATION

I, ________________________________ (patient), hereby authorize the physicians and staff of Dearborn Orthopedics & Sports Medicine, PC to give the following people information concerning my health and well-being:
Appointment time, test results, medication and/or written prescriptions, procedures, medical records and/or x-rays. (circle)

_____ I authorize the release of all medical information

____

Parent(s)/Guardian if a minor child   Relationship

____

Name   Relationship

____

Name   Relationship

____

Pharmacy (diagnosis only)

_____ I do not authorize the release of any medical information

If delay in treatment results because we cannot relay information to another party, Dearborn Orthopedics & Sports Medicine, PC will not be held responsible. By signing below, you acknowledge a copy of our HIPAA policy is available for your review upon request.

____   ______________________

Signature of Patient, Parent/Legal Guardian   Date