PERMISSION TO GIVE MEDICAL INFORMATION

☐ I authorize my medical diagnosis to be released to the following pharmacy for the dispensing of medications:

____

☐ I authorize the release of information including appointment time, test results, medication and/or written prescriptions, procedures, medical records and/or x-rays. This information may be released to:

Spouse Name: ____

Child(ren) Name(s): ____

Parent(s) Name(s): ____

Other Name: ____

☐ I do not authorize the release of any medical information.

If delay in treatment results because we cannot relay information to another party, Dearborn/Livonia 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