GOTHAM CITY ORTHOPEDICS, LLC

Authorization for Release of Protected Health Information

I authorize the staff and/or physicians at **Gotham City Orthopedics, LLC** to discuss my healthcare, diagnosis, test results, procedures, prognosis, insurance and billing information with the following person(s) for the purpose of my treatment or payment of services rendered *:

_____ _____
Name of designated person Relationship to patient

_____ _____
Name of designated person Relationship to patient

☐ **I DO NOT wish to designate any person(s) ***

**Please note for children under 18 years of age, information will be released to the parent or legal guardian.*

I understand that in order to ensure continuation of care, the staff and/or physicians at **Gotham City Orthopedics,LLC** may need to leave messages on the answering machine at my home or with any individual(s) who may answer my home phone. These messages may include but are not limited to: appointment confirmations, lab results, radiology results, pathology results, etc.

☐ **I DO wish to have messages left** ☐ **I DO NOT wish to have messages left**

I also understand that by designating the above individual(s) or facility(s), I am allowing my Protected Health Information (medical records/ information) to be discussed or released to them. I know that this is my personal choice and I have not been forced to designate any individual(s) or facility(s) if I have chosen not to.

_____ X_____
Patient Printed Name Patient Signature

____/____/_____
Date

Privacy Practices Acknowledgement

I have reviewed / received the Notice of Privacy Practices for **Gotham City Orthopedics, LLC**

_____ X_____
Patient Printed Name Patient Signature

____/____/_____
Date