



BROOKWOOD
O R T H O P E D I C S

care in motion

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Social Security #:** _____

I hereby authorize Brookwood Orthopedics, its physicians, employees and/or representatives to use and/or disclose my protected health information (PHI) including my account and medical conditions which may include symptoms, treatments, diagnoses, test results, medications and other health information to the following persons (a) in order to facilitate and coordinate my care, treatment and payment for medical care and treatment or (b) at their request.

NAME	RELATIONSHIP	TELEPHONE#

I understand that authorizing the release of my information to the above individual(s) is voluntary and the practice may not refuse to provide treatment to me if I do not sign this form. I can revoke it by writing Brookwood Orthopedics or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that any PHI which is used and/or disclosed to the above individuals may be subject to re-disclosure by the individual(s) and may no longer be protected by federal or state law. I agree to release the practice, its employees, agents, officers, and directors from any and all liabilities and responsibilities for the disclosure of the above information to the extent indicated and authorized pursuant to this signed authorization.

Patient Signature or Legal Representative : _____

Date: _____