



**PATIENT'S CONTACT – OUTPATIENT VISIT
AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)**

I give ORTHOPAEDIC ASSOCIATES OF WI permission to leave messages and communicate detailed protected health information (PHI) known about me now and in the future. ORTHOPAEDIC ASSOCIATES OF WI may leave general telephone appointment reminders and messages requesting that I call back even if I do not sign this form.

PATIENT INFORMATION

First Name _____ M.I. _____ Last Name _____

Date of Birth _____

COMMUNICATION PREFERENCES

Method	Phone/Email	Voicemail OK	With Someone OK
Cell	(_____) _____ - _____	☐	☐
Home	(_____) _____ - _____	☐	☐
Email		Ok to Email	☐

In addition to the above, you may also release information to the following individual(s):		
Name	Relationship	Phone
		(_____) _____ - _____
		(_____) _____ - _____
		(_____) _____ - _____

AUTHORIZATION AND ACKNOWLEDGMENT

I understand what information about me may be communicated with my contacts. This accurately reflects my wishes. I authorize ORTHOPAEDIC ASSOCIATES OF WI to use the information I have provided on this page of this form.

X Patient or Legal Guardian/Representative _____
Signature: _____
Relationship (if not patient) _____ Date _____

Note: Legal Guardian/Representative means the parent, guardian, or legal custodian of minor patient or adult patient. If you have Durable Power of Attorney, documentation is required before release of information.

CONSENT FOR TREATMENT OF A MINOR (IF APPLICABLE)

Minor's Full Legal Name	Parent/Guardian Name
Relationship	Date

I am giving permission for ORTHOPAEDIC ASSOCIATES OF WI to administer medical treatment to my minor child without my presence. This consent will remain in effect until further notice is given in writing.

Signature: _____