Orthopedic Surgeons of Kokomo

PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

This form will allow us to share your health care information with individuals you specify below

PATIENT INFORMATION

Name of Patient:	Date of Birth:	Phone Number:
Address:	City/State/Zip:	Social Security Number:

I (the undersigned) hereby consent to Orthopedic Surgeons of Kokomo, LLC (hereafter referred to as OSK) leaving a voicemail message at the number indicated above and/or discussing with the individual listed below, information related to my protected health information (hereafter referred to as PHI). These communications may include, but are not limited to, appointment reminders, medications, pre-registration, billing and insurance items, and any other information pertaining to clinical health services, such as laboratory and test results. I understand that this consent is only valid at OSK.

YOUR RIGHTS WITH RESPECT TO THIS CONSENT:
I understand that I have the right to revoke this consent at any time by sending a written statement to OSK, except to the extent OSK has already made a disclosure in reliance upon my prior consent. This consent is valid until I revoke it in a written statement.

*With my consent, OSK may release my PHI to the following individual:

Name:	Relationship to Patient:
Date of Birth:	Phone Number:

I understand that the information listed above may be communicated via fax, photocopy, verbal communication, telephone, voicemail and/or direct mail. I further understand that this consent **does not permit the release of my actual medical records** to the individual listed above. I will have to sign a separate authorization form provided by OSK.

_____ _____

Signature of Patient **or** Legal Representative Date

_____ _____

Legal Representation Relationship and authority Signature of Witness

Legal Authority: ( ) Custodial Parent ( ) Legal Guardian ( ) Authorized Legal Representative
(mark one)