ORTHOPEDIC & SPORTS
INSTITUTE OF THE FOX VALLEY™

Orthopedic and Sports Institute of the Fox Valley

Permissions to Verbally Discuss Health Information

You can designate others to whom Orthopedic and Sports Institute (OSI) can verbally discuss your medical information (including your health status, condition, location, appointment and scheduling information, lab and test results, and billing information). This authorization does not allow OSI to provide or release your medical and / or billing records to anyone as that would require a separate authorization.

Complete this form to let us know to whom we may speak about your information. Here are some examples of when it might be useful to you to release information:

- If you want a relative or friend to help understand medical treatment instructions
- If you want a relative or friend to help you understand your bills
- If a relative or friend comes in and asks if you are here and where you are in the building

I give permission for OSI to discuss my information with the following people. It is requested (not required) to have all parents names listed below for all minor patients.

Full Name	Relationship	Phone Number

☐ Do not provide my health information to anyone

I am not required to sign this form in order to be provided treatment, payment, enrollment in a health plan, or eligibility for benefits. The persons(s) I am authorizing to receive my health information may release my health information without my knowledge and may not be required to follow federal or state privacy standards.

This authorization that I am providing is effective until my legal representative or I cancel it. Also I may cancel this authorization to release my health information by completing and providing a new completed form to the appropriate OSI clinic business office. Cancellation does not apply to health information already released in response to this authorization. I understand that if someone not listed above requests information about me, the request will be denied.

I understand what health information about me will be released. This accurately reflects my wishes.

_____ _____ _____

Signature of Patient/ Authorized Legal Representative* Date Time

***Name of the Legal representative completing this form:** _____

Legal authority*: □ Parent **By signing above, I am confirming that I have not been denied physical placement of this child
□ Legal guardian □ Next of kin / executer of deceased □ Activated POA for Health Care □ Other: _____
(legal documentation required)