STRASBURGER ORTHOPAEDICS, P.C.

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CONSENT TO RELEASE MEDIAL AND BILLING INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), allows your healthcare provider or staff of Strasburger Orthopaedics, P.C. (Practice), to discuss your medical or billing information with members of your family or other individuals involved in your medical care upon your approval, or when given the opportunity, you do not object, or when your healthcare provider reasonably infers from the circumstances, based on his/her professional judgment, that you do not object to such disclosure. To assist our Practice in determining your desires with respect to such disclosures, we ask that you complete this form. You may revoke or modify this consent at any time by submitting a revised form.

______I **do not authorize** Practice to disclose any information concerning my medical care and billing information to family members, other relatives, personal friends, or any other person; provided, however, in the event I am incapacitated or there is an emergency situation, my healthcare provider may disclose my medical and billing information, whether in person, over the phone, or in writing, that is directly relevant to those involved in my medical care, if the healthcare provider, based on his/her professional judgment, determines the disclosure is in my best interest.

_____I **authorize** Practice to disclose, to the following individuals, medical care and billing information, whether in person, over the phone, or in writing, directly relevant to such individual's involvement with my medical care or payment related to my medical care; provided, however, in the event I am incapacitated or there is an emergency situation, my healthcare provider may disclose my medical and billing information, whether in person, over the phone, or in writing, that is directly relevant to those involved in my medical care, even though their name does not appear below, if the healthcare provider, based on his/her professional judgment, determines the disclosure is in my best interest.

Name	Relationship to patient
______________________________	______________________________
Name	Relationship to patient
______________________________	______________________________
Name	Relationship to patient
______________________________	______________________________
Name	Relationship to patient

______________________________ ____________________

Print Patient Name **Date of Birth**

______________________________ ____________________

Patient signature **Date**