

Patient Name: _____ Birthdate: _____

To preserve your privacy as a patient of Easton Orthopaedic Group, we need your permission to allow us to contact you or someone you might designate, outside of your office visits.

In the event that you are not able to answer your telephone, we need permission to leave certain types of information on your answering machine or with another person. Without specific permission specified below, we will not release any of your medical or billing information.

- Do not leave medical information pertaining to my care on my home answering machine or with any other person.
- I authorize the physicians and/or staff at Easton Orthopaedic Group to leave messages regarding appointment reminders and insurance coverage/benefits issues on a telephone answering machine or with the person/people indicated below.

The following is a list of people who I authorize to receive information regarding all aspects of my care with Easton Orthopaedic Group:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

I am aware that it is my responsibility to inform Easton Orthopaedic Group of any changes in my phone number, address or insurance information as well as any changes to the above privacy authorizations.

Signature of Patient/Parent of Guardian: _____ Date: _____

Witness: _____

Workmen's Compensation Patients

Your employer may request information regarding your condition if you are being treated for a workmen's compensation injury. This information is provided to the Insurance carrier by law. Please sign below to authorize release of this information to your employer.

Signature of Patient: _____ Date: _____