PATIENT CONSENT TO SHARE PROTECTED HEALTH INFORMATION

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

PATIENT INFORMATION

Name of Patient:	Date of Birth:	Phone:

I (the undersigned) hereby consent to Orthopedic Surgeons of Kokomo, LLC (hereafter referred 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 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 Representative Relationship and authority) **Signature of Witness**

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased

☐ Authorized Legal Representative

I acknowledge a copy of Orthopedic Surgeons of Kokomo Privacy Policy has been made available to me.

_____
Signature Date