

Release of Medical Information

To Others Involved in Your Healthcare

As stated in our Notice of Privacy Practices, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We request that you designate the individuals with whom we may discuss your protected health information.

I, _____ give **Interlakes Orthopaedic Surgery** and/or the colleagues permission to discuss my protected health information with the following persons:

Name

Phone Number

Patient Signature

Date

Witness Signature

Date

I understand that I may rescind or modify this permission at any time. Such change must be in writing to Interlakes Orthopaedic Surgery.