OSC
Premier Bone and Joint Surgeons

INFORMATION RELEASE CONSENT FORM

To protect your privacy, we need you to provide us a list of family/friends that we can release your information to. If you do not want any information released to anyone, please draw a line through the top portion of the form and complete the bottom portion.

I give Orthopaedic Specialty Clinic of Spokane, PLLC permission to discuss and/or release any and all confidential information of any kind, (personal, medical, financial-anything & everything) that they have in their possession regarding myself to the following people:

1. _____Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

This is to include information regarding HIV (aids virus), STD (sexually transmitted diseases), pregnancy testing/reproduction and or sexuality rights, psychiatric disorders/mental health and drug/alcohol abuse.

****There may be a charge for any duplication of records and or films****

Patients name (please print): _____

Patients Date of Birth: ____/____/____

Patients signature: _____

Today's Date: ____/____/____

This release shall remain valid for one year from the date of signature or until it is revoked in writing.

Updated: 4-4-12

(Office policies: Information release consent form 12-14-11)

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