Orthopedic Associates – 65 Pennsylvania Avenue – Binghamton, NY 13903

Authorization to Share Information

PATIENT NAME: _____

DATE OF BIRTH: _____

I authorize the following individual(s) (18 years old or older) to discuss my medical condition, appointment information and billing issues. I authorize the same individual(s) (below) to pickup copies of my medical records, prescriptions and x-rays.

1. _____

2. _____

OPTIONAL

If it is necessary for this office to mail any information to you, it will be sent to your home address.

Please list a telephone number where we can reach you or leave a detailed message if necessary. _____

Would you like us to share your office visit progress notes with your primary care physician? YES NO (Please circle one). If yes, please provide us with the following information:

_____

Doctor's Full Name

_____

Doctor's Street Address

_____

Doctor's City, State and Zip Code

Patient Name or Legal Representative (signature): _____

If Legal Rep, relationship to Patient: _____

Date: _____

This authorization will expire one year from date of signature (unless otherwise notified).