

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Orthopedic Solutions to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Orthopedic Solutions to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Orthopedic Solutions charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Orthopedic Solutions, its agents and its employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Orthopedic Solutions. I understand I am financially responsible for charges not covered by this assignment.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Orthopedic Solutions from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED _____ **DATE** _____
(PATIENT)

OR _____ **WITNESS**
TO SIGNATURE _____
(NEAREST RELATIVE OR RESPONSIBLE PARTY)

(RELATIONSHIP TO PATIENT) **POLICYHOLDER'S**
SIGNATURE _____

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made a confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.