Orthopedic Surgeons of Wisconsin, SC

Authorization to Release Information

Many of our patients allow specified individuals such as their spouse, parent or others to call and request the results of tests and procedures; or to contact us on their behalf to assist in explaining their statements. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have other specified individuals permitted to contact us on your behalf for the aforementioned purpose(s), you must specify to whom we may speak and you must sign this form.

I authorize Orthopedic Surgeons of Wisconsin, SC to release my results and reports; and/or to discuss matters relating to my statements with the following individuals.

1. _____Phone# ( )_____ Relationship to Patient: _____

2. _____Phone# ( )_____ Relationship to Patient: _____

3. _____Phone# ( )_____ Relationship to Patient: _____

Name of Patient: _____

Signature of Patient: _____ Date: _____

Authorization to Leave Message with Household Members/Answering Machine

From time to time it is necessary for representatives of Orthopedic Surgeons of Wisconsin, SC to leave a message for our patients. The purpose of these messages are to remind patients that they have an appointment, to notify the patients that medical staff would like to discuss lab or procedure results, or to ask a patient to call OIW regarding an issue or concern. At no time will a representative of OIW discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Patient: _____

Signature of Patient: _____ Date: _____