

# Medical Release Form for Protected Health Information

I, \_\_\_\_\_ (date of birth) \_\_/\_\_/\_\_\_\_), give Moore Orthopedics & Sports Medicine, P.A., permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Moore Orthopedics & Sports Medicine, P.A. This consent is valid until such time as I provide Moore Orthopedics & Sports Medicine, P.A. written revocation of it.

Moore Orthopedics & Sports Medicine, P.A. may speak with:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Restrictions

May we call you at work? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Leave a message on your answering machine? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Send an appointment reminder? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Call on a cell phone? Yes \_\_\_ No \_\_\_ N/A \_\_\_

Any other restrictions? \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

Moore Orthopedics & Sports Medicine, P.A. employee: \_\_\_\_\_ date :

\_\_\_\_/\_\_\_\_/\_\_\_\_

Restriction's accepted by Moore Orthopedics & Sports Medicine: yes \_\_\_ No \_\_\_ N/A \_\_\_

I, \_\_\_\_\_ request and authorize Moore Orthopedics & Sports Medicine to appeal any claims on my behalf, should my insurance company fail to pay my claim in full. They have my permission to submit my medical records on my behalf.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

