



PLEASE FILL IN ALL HIGHLIGHTED SPACES BELOW

Today's Date Patient's SSN#

Legal First Name Last Name M.I. DOB Gender

Parent/Guardian Name (for pediatrics) DOB

Address City State Zip

Home Phone Cell Phone Work Phone

Email

Have any members of your family been seen in our office before: Yes No

*If Yes, Please list the following names:

Emergency Contact Name Relationship to Patient Phone

Race: White Asian Black/African American American Indian/Alaskan Native

Native Hawaiian/Other Pacific Islander Refuse to Report

Ethnicity: Hispanic / Latino Not Hispanic/Latino Refuse to Report

Language: English Spanish Indian Japanese Chinese Korean French

German Russian Other:

Pharmacy Name: Address: Phone:

Primary Insurance Co.

Name Phone

Policy Holder Name Relationship to Patient SSN DOB

(If Insurance is Medicaid, Policy Holder is Patient)

Policy Holder's Address (If Different): City State Zip

Employer Name ID# Group #

Secondary Insurance Co.

Name Phone

Policy Holder Name Relationship to Patient SSN DOB

Policy Holder's Address (If Different): City State Zip

Employer Name ID# Group #

PRIMARY CARE PHYSICIAN

Name of Practice

Physician Name

Address

City/State/Zip

Phone

Fax

School District:

HOW DID YOU LEARN ABOUT US?

Primary Care Physician Self Family/Friends Website Healthgrades.com Blog

Vitals.com Search Engine Facebook Yelp.com Physician Directory Twitter

Google Places Sport Organization: Other:

Emergency Room/ Urgent Care/ Emergency Department (Please circle):

P/S/L Rocky Mountain Hospital for Children Centennial Medical Center of Aurora Sky Ridge Swedish Rose North Suburban North East ER Avista Littleton Porter St. Anthony's Parker

Other:

ROCKY MOUNTAIN PEDIATRIC ORTHOONE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page). The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is** _____.

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.

I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I decline _____ (Patient/ Representative Initials) to receive communication via email.

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
 - Name: _____ Date: _____
 - Name: _____ Date: _____
- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ **Date:** _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____



Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ **Time:** _____



General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Printed Name of Witness

Employee Job Title

Signature of Witness

Date



Patient/Parent Consent for Financial Communications

Patient Name: _____ DOB: _____

We would like to thank you for choosing **Rocky Mountain Pediatric Orthopedics, Scoliosis & Spine, Youth Sports Medicine and Center for Concussion** for your and or your child's care. We are committed to providing you with the best possible care. We want you to be informed of our office financial policy and require a signature to document that you have read and understand our policy. You will be given a copy for your records upon request.

1. SERVICE

Your/ your child is here to receive a service. There are charges associated with the services we provide. Services include, but are not limited to: consultation, evaluation, and procedures. Services provided outside of our office will be charged by the entity providing the service. (i.e: labs, MRIs, CT Scans, and DEXA Scans)

_____ Patient/ Representative Initials

2. MISSED APPOINTMENT/LATE CANCELLATION

Our office will call to confirm your/ your child's appointment two (2) business days prior to the appointment date. Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. In order to maintain our schedule, we request **24 hour notice** for cancellations or rescheduling of appointments.

_____ Patient/ Representative Initials

3. CHECK IN

We respect and value your time. **If you are more than 15 minutes late for your appointment, we may need to reschedule.** We apologize for any inconvenience this may cause you, but we do our best to run on time and by being punctual, everyone will be served in a timely and efficient manner while receiving the highest quality care.

ESTABLISHED PATIENTS: We request that **all** of our established patients **arrive 15 minutes prior** to their appointment for any paperwork process that may be required at check in.

NEW PATIENTS: If it is your first time to our office, **please arrive 30 minutes prior to your appointment time with your paper work completed.** If you were unable to complete the paperwork, we still request that you come in **30 minutes early** to ensure that appropriate paperwork is completed.

_____ Patient/ Representative Initials

4. PAYMENT

For patients with a **co-pay** plan, payment is expected at the time of service. When you check in for the appointment, we will collect the amount indicated on your card unless otherwise instructed. We accept credit cards, checks and cash.

All insurance carriers have a fee schedule from which they will reimburse. Any services not covered such as **deductibles and coinsurance** are your responsibility and will be billed to you by our office. Payment is due within 30 days upon receipt.

_____ Patient/ Representative Initials

5. SELF PAY

If you do not have insurance, payment is required at the time of service. If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by speaking with one of our staff. Once your bill is processed through our system there may be an additional balance due to us, or due back to you.

_____ **Patient/ Representative Initials**

6. INSURANCE

- I acknowledge, that as a courtesy, Rocky Mountain Pediatric Orthopedics may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductibles, or charges not covered by insurance.
- I understand there is a fee for returned checks.

_____ **Patient/ Representative Initials**

7. ASSIGNMENT OF BENEFITS

I hereby assign to Rocky Mountain Pediatric Orthopedics any insurance benefits available for health care services provided to me. I understand Rocky Mountain Pediatric Orthopedics has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Rocky Mountain Pediatric Orthopedics, I agree to forward all health insurance payments that I receive for services rendered to me immediately upon request.

_____ **Patient/ Representative Initials**

8. INSURANCE REFERRALS

It is your responsibility to understand the requirements of your insurance policy. If a referral is needed prior to seeing a specialist, you will need to obtain one through your primary care doctor office before an appointment can be made. If you choose to be seen without a valid referral in place, you will be responsible for any charges not covered by your insurance company.

_____ **Patient/ Representative Initials**

9. FRACTURE CARE

If we treat you or your dependent for a fracture your insurance company requires that we bill our services to you using a coding system known as CPT (Current Procedure Terminology). The codes used to describe the services we completed for you are found in the "surgery" section of the CPT code book. This does not mean that you had an operation. This is merely the way the CPT code book is organized for ease of use by both insurance companies and physicians. This code is used for most closed fracture treatments with or without any kind of manipulation. In some cases closed treatment may just mean the specialist has diagnosed a fracture and recommends keeping the fractured arm in a sling.

According to the CPT guidelines, fracture care is billed as a "packaged" service.

This means that at the time of initial care, a bill is generated that includes:

1. Treatment of the fracture
2. The first cast or splint application
3. 90 days of normal, uncomplicated, follow up care

The procedures and other items NOT included in the package are:

1. X-rays
2. All casting supplies (including those used with the first cast application)
3. Any replacement cast application
4. The evaluation and management of any additional problems or injuries
5. The treatment of complications

There will be a separate charge for these services.

Your insurance company may cover the care rendered for fractures differently than for office visits. Therefore, when you receive the explanation of insurance benefits, the services may be paid as a surgical procedure with deductible and co-insurance guidelines applied. We are using the most appropriate code available to describe the care rendered. We are required legally to use this code to bill for this service. As always, we encourage you to check with your insurance company and verify the benefits available. If you have any questions, please do not hesitate to contact us.

If you have any questions, please do not hesitate to call our billing office at (303) 861-2663.

I certify that I have read and fully understand the above statements.

_____ **Patient/ Representative Initials**

10. CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATIONS

I agree that, in order for Rocky Mountain Pediatric Orthopedics, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Rocky Mountain Pediatric Orthopedics or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Rocky Mountain Pediatric Orthopedics or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.

_____ **Patient/ Representative Initials**

11. PHOTOCOPY

A photocopy of this consent shall be considered as valid as the original.

_____ **Patient/ Representative Initials**

Patient/ Representative Signature: _____ **Date:** _____

If you are not the Patient, please identify your Relationship to the Patient.

- Spouse Guarantor
- Parent Healthcare Power of Attorney
- Legal Guardian Other (please specify) _____

Rocky Mountain Pediatric OrthoONE

Patient Medical History

Today's Date: _____ Primary Care Physician: _____

Referring Provider: _____

Patient's Legal First Name: _____ MI: ___ Last Name: _____

DOB: _____ Gender: _____ Age: _____

Grade in School: _____ Birth Weight: _____ Dominant Hand: _____ Height: _____ Weight: _____

School Name: _____ School District: _____

Reason for today's visit (Chief Complaint): _____

How did it occur: _____









Is this a: Recent Injury(with in last month) Old Injury On-going problem/pain Second Opinion

Which Side: Right Left Bilateral (both) BODY PART(s): _____

Date of Injury/Pain Began: _____

Did you have: X-RAYS CT SCAN MRI Labs None Other _____ Do you have them with you? Yes No

Did you visit an Emergency Department/ Urgent Care? Yes No Facility Name: _____ Date: _____

FRONT	BACK	Describe your pain/symptoms:	What is your pain level today?
RIGHT LEFT	LEFT RIGHT		
		<input type="checkbox"/> Shooting <input type="checkbox"/> Tingling <input type="checkbox"/> Numb <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Stinging <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Sharp	<p style="text-align: center;">No Pain Moderate Pain Worst Pain</p> <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p> <div style="display: flex; justify-content: space-around; align-items: center;">       </div>

What makes the pain better? _____ What makes the pain worse? _____

Received treatment for this Injury/Problem? Yes No If Yes, please choose the following options:

Medication-List below in Current Medication Compression (Ace Wrap) Elevation Physical Therapy

Splinted/ Temp Cast Ice Crutches Other: _____

Medical Information

Current Medication: _____ **Dose & Frequency:** _____ Check if None

Medical Problems: _____ Check if None

Allergies & Reactions: _____ Check if None

Surgeries and Dates: _____ Check if None

Hospitalization and Dates: _____ Check if None

***Please see the back/next of the page for additional space.

Family History

Parent's/Guardian's Name: _____ Occupation: _____

Parent's/Guardian's Name: _____ Occupation: _____

Please indicate the PATIENT'S family member that has the below family history(FOR THE PATIENT):

- | | |
|---|---|
| 1. Orthopedic Problems – Mom, Dad, Brother, Sister | 2. Scoliosis – Mom, Dad, Brother, Sister |
| 3. Hip Dysplasia – Mom, Dad, Brother, Sister | 4. Diabetes – Mom, Dad, Brother, Sister |
| 5. Hypertension – Mom, Dad, Brother, Sister | 6. Breast Cancer – Mom, Dad, Brother, Sister |
| 7. Coronary Artery Disease – Mom, Dad, Brother, Sister | 8. Lung Cancer – Mom, Dad, Brother, Sister |
| 9. Colon Cancer – Mom, Dad, Brother, Sister | 10. Heart Attack – Mom, Dad, Brother, Sister |
| 11. High Cholesterol – Mom, Dad, Brother, Sister | 12. Asthma – Mom, Dad, Brother, Sister |

13. Other: _____ Mom, Dad, Brother, Sister **Check if ALL Family History is None**

Mom: Alive / Deceased Dad: Alive / Deceased Sister(s): Alive / Deceased Brother(s): Alive / Deceased

Social History

Who lives with you: _____

Tobacco/Nicotine Use: Never Current Former

(13 and Older)

Sports/Hobbies: _____

Do you exercise? Yes No _____ Days per week you exercise. _____ Hours per day you exercise.

Name of Sports Organization/Team: _____

Immunizations

Influenza-Flu Shot (All Ages) Yes/Month and Year: _____ No Refused

Immunizations up to date? Yes No

Review of Systems (Past & Present)

Check if all are Negative

Psychiatric:

- Depression
- Emotional Difficulties

Respiratory:

- Coughing
- Asthma
- Shortness of Breath
- Wheezing

Hematologic:

- Bleeding Problems
- Bruise Easily
- Anemia
- Clotting Problems

Gastrointestinal:

- Stomach Pain
- Heart Burn

Genitourinary:

- Blood in Urine
- Urinary Difficulties

Dermatologic:

- Rash
- Eczema
- Keloids/Hypertrophic Scarring

Cardiovascular:

- Chest Pain
- Palpitations
- Murmur

Eyes, ears, nose, throat:

- Vision/Hearing problems
- Nose Bleeds
- Sinus Problems

Constitutional symptoms:

- Fatigue
- Fever
- Weight Loss
- Night Sweats

Musculoskeletal:

- Joint/Muscles Aches

Neurologic:

- Balance Problems
- Seizure
- Other: _____

Endocrine:

- Low/High Blood Sugar
- Low/High Thyroid Functioning

Cancer: _____ **Other:** _____

Patient Name: _____ **DOB:** _____

Parent/Responsible Party Signature: _____ **Date:** _____

**HCA PHYSICIAN SERVICES
ORTHOONE
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Section A: This section must be completed for all Authorizations					
Patient Name:	Date of Birth:	Patient's Phone:	Last 4 digit SSN (optional):		
Provider's Name:	Recipient's Name:				
Provider's Address:	Address 1:				
	Address 2:			Recipient's Phone:	
	City:		State:	Zip:	
Request Delivery (If left blank, a paper copy will be provided): <input type="checkbox"/> Paper Copy <input type="checkbox"/> Electronic Media, if available (e.g., USB drive, CD/DVD) <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Unencrypted Email					
NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.					
Email Address (If email checked above. Please print legibly):					
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
Date: _____ Event: _____					
Purpose of disclosure:					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical test <input type="checkbox"/> Medication sheets		<input type="checkbox"/> Operative information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER information		<input type="checkbox"/> Labor/delivery summary <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-04: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary. 2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it. 6. I get a copy of this form after I sign it.					
Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial remuneration in exchange for using or disclosing this information? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, describe:					
May the recipient of the PHI further exchange the information for financial remuneration? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Patient's Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	