TAHOE FOREST ORTHOPEDICS & SPORTS MEDICINE

Exceptional Care Begins Here

10051 Lake Avenue, Suite 3 • Truckee, CA 96161
Main Office: (530) 587-7461 • Fax: (530) 587-1149

Authorization for Verbal Communication of Protected Health Information

Medical Record #: _____

Patient Name (Please Print): _____ Date of Birth: _____

My signature below indicates my agreement to the following (check each applicable item):

Protected Health Information: Please indicate with whom we may discuss your Protected Health Information:

❑ None, discuss only with me.

❑ You may discuss my Protected Health Information with the following person(s):

1. Name: _____ Relationship: _____
   Address: _____
   Phone Number(s): _____
   ❑ I want this authorization to end on (date): _____ ❑ There is no end date.

2. Name: _____ Relationship: _____
   Address: _____
   Phone Number(s): _____
   ❑ I want this authorization to end on (date): _____ ❑ There is no end date.

Insurance/Billing Information: Please indicate with whom we may discuss insurance and billing matters:*

❑ None, discuss only with me.

❑ You may discuss my medical billing with the following person(s):* Write "same" if same as above.

1. Name: _____ Relationship: _____
   Address: _____
   Phone Number(s): _____
   ❑ I want this authorization to end on (date): _____ ❑ There is no end date.

2. Name: _____ Relationship: _____
   Address: _____
   Phone Number(s): _____
   ❑ I want this authorization to end on (date): _____ ❑ There is no end date.

*Please note that the provisions of your insurance policy and applicable regulations may permit us to discuss insurance/billing information with persons not indicated here.

Signature of Patient or Authorized Representative:
_____ Date: _____

Print Name: _____ Relationship: _____