ORTHOPEDIC ASSOCIATES
OADoctors.com 800-824-9861

CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION TO PERSONAL REPRESENTATIVES

Patient Name:	
Address:	
City, State & Zip:	
Telephone Number:	
Date:	
Race:	[ ] Black or African American [ ] White [ ] Hispanic [ ] Other
Language	[ ] English [ ] Spanish [ ] Other
Ethnicity	[ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Other

I, _____, give my written consent for Orthopedic Associates of SW Ohio to share information regarding my protected health information and care to the following listed persons; I understand that these persons may be treated as personal representatives of myself.

Personal Representatives that you may share my health information with:

_____

(Name) (Relationship)

_____

(Name) (Relationship)

_____

(Name) (Relationship)

You may leave a message: (please check all that apply)

At Home [ ] At Work [ ] Cell Phone [ ]

_____

Patient's Signature Witness' Signature

_____

Date Date

Do not discuss my information with anyone other than myself at any time. [ ]

*(Must complete "Request for Confidential Communication of Protected Health Information" form.)