ALLEGIANCE ORTHOPEDIC AND SPINE INSTITUTE, PLLC

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PATIENT RECORD OF PERSONAL HEALTH INFORMATION DISCLOSURE

PATIENT NAME: _____ DATE OF BIRTH: _____

YOU MAY DISCLOSE MY MEDICAL INFORMATION / MEDICAL RECORDS TO THE PROVIDERS CIRCLED:

- ALL LISTED BELOW
- PRIMARY CARE PHYSICIAN
- REFERRING PHYSICIAN
- ATTORNEY REPRESENTING MY INTEREST
- AUTO INSURANCE
- HEALTH INSURANCE CARRIER
- ENTITY TO WHOM WE HAVE REFERRED YOU TO FOR CONTINUATION OF CARE
- AND TO: _____

YOU MAY DISCLOSE MY MEDICAL INFORMATION / MEDICAL RECORDS TO THE FOLLOWING:

- NAME: _____ RELATIONSHIP: _____
- NAME: _____ RELATIONSHIP: _____
- NAME: _____ RELATIONSHIP: _____

_____

(PRINTED NAME OF PARENT OR GUARDIAN IF PROVIDING SIGNATURE) SIGNATURE DATE