Clinic Family and Friends - Authorization Form

Name: **Date of Birth:**

Orthopedics Northwest does not share your health information with family or friends without your permission. This may include information about:

- Illness or injury
- Treatment
- Medications
- Appointments
- Test Results
- Billing and Insurance

If you want us to share your health information with family or friends, please list their names below. You can add or remove people from this list at any time.

I give permission for my health information to be shared with:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

❑ **I choose NOT to have my health information discussed with family or friends.**

Authorization Terms:

I understand that allowing others to view my health information is voluntary.

I understand that I do not need to sign this form to receive medical care.

I understand that my health information may include information related to sexually transmitted diseases, drug and/or alcohol abuse treatment, mental health care or other sensitive information.

Signature: ______________________________ **Date:** ______________