Central Indiana Orthopedics
INVESTED IN KEEPING YOU ACTIVE

Consent for Communication of Protected Health Information to Personal Representatives

Name: _____
Address: _____
City, State, and ZIP: _____
Telephone number: _____
Date: _____

I, _____, give my written consent for Central Indiana Orthopedics 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 ☐ On Answering Machine

Verification Data: _____
(Mother's maiden name or other ID we can use)

_____
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).

For Internal Purposes Only

Account Number: _____ Entered Into Computer Date: _____
Employee Name: _____