Dungy Orthopedic Center
Permission to Release Records

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. If we change our notice, you may obtain a revised copy by request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about your treatment, payment and health care operations.

Please specify which of these phone numbers we may leave a message on:

☐ Mobile ☐ Home ☐ Work ☐ None

Release of Information

Please list any individual(s) you want to allow verbal and/or physical access to your health care information. This includes any other healthcare provider or facility. This release will be retained in your medical record unless it is revoked or amended in writing.

Name:	Relationship:	Phone Number:

Emergency Contact

Unless otherwise specified, this person has the ability to verbally and/or physically access your health care information.

Name:	Relationship:	Phone Number:

Print Patient Name:____ DOB: ____________

Patient/Representative Signature:____________________________________ Date:____________