Premier ORTHOPAEDICS

INFORMATION DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

I authorize Premier Orthopaedic and Sports Medicine Associates, Ltd. ("Premier"), to disclose information about my care and treatment to the individuals listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAME(S) OF INDIVIDUAL(S)	RELATIONSHIP(S) TO PATIENT	INFORMATION TO DISCLOSE
_____	_____	☐ Treatment ☐ Payment
_____	_____	☐ Treatment ☐ Payment
_____	_____	☐ Treatment ☐ Payment

Authorization to leave answering machine/voicemail messages ☐ Yes ☐ No

_____
Patient Name (Printed)

_____ _____
Signature of Patient/Representative Date