

ORTHOPEDIC & SPORTS SPECIALISTS OF LOUISVILLE, PSC

CONSENT FORM

Patient Name: _____
(Please print full name)

In case that I need Orthopedic & Sports Specialists, P.S.C. to speak to someone other than myself regarding my medical care or my account information, I authorize the following person(s) to do so:

(Name)

(Relation to patient)

(Name)

(Relation to patient)

(Name)

(Relation to patient)

I understand that in the case that I do **not** want any such person listed above to have the authorization to talk to Orthopedic & Sports Specialists, P.S.C. regarding my medical care or account information; it is my sole responsibility to inform Orthopedic & Sports Specialists, P.S.C. in writing of this immediately. We will use reasonable efforts to identify the persons(s) designated providing that we bear no responsibility for disclosures for individuals who misrepresent themselves.

(Signature)

(Date)