

ORTHOPEDIC GROUP, INC.

Patient Consent To Disclose Personal Health & Financial Information

I, _____, authorize Orthopedic Group, Inc. to release my health
(Print your name)
and/or financial information, as indicated below, to the following individual(s):

Name: _____

Address: _____

Information authorized to disclose (please check the appropriate box):

- all of my personal health and/or financial information
- only the following personal health and/or financial information: _____
- only personal health and/or financial information related to today's visit
- only personal health and/or financial information related to today's visit and future visits
- Other selected information: _____

I authorize _____ to be present with me in the examination room
(Print name of individual)

I understand and am comfortable with the above authorization for disclosing this personal health and/or financial information to the person(s) noted above and, if applicable, authorizing the above individual to be present during my exam. I also understand that I can refuse to sign this consent form.

(Signature of Patient or Legal Representative)

(Date)

(If Signed by Legal Representative, Relationship to Patient)

(Signature of Witness)

Interpreter / Translator Waiver Information

By signing in the space below, I am giving my consent to proceed with my upcoming appointment. I understand that an interpreter or translator for the hearing-impaired will not be present during this appointment.

In addition, I acknowledge that I was offered the option of rescheduling today's appointment, but have decided instead to proceed with the appointment as scheduled.

At the conclusion of the visit, should I have any questions or concerns, or if there should be any information that I do not fully understand, I understand that it is my responsibility to make this known to the physician prior to leaving the office.

I authorize _____ to be present with me in the examination room/office area and to act as a translator and/or interpreter of the communication between myself and the doctor. I am allowing this person to accept the responsibility of communicating information about my health and treatment:

(Signature of above authorized individual)

(Date)

(Signature of Patient or Legal Representative)

(Date)

(If Signed by Legal Representative, Relationship to Patient)

(Signature of Witness)