San Antonio
Hand to Shoulder
Orthopaedic Center

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PLEASE READ THIS THOROUGHLY AND CAREFULLY

HIPAA: Health Insurance Portability and Accountability Act

HIPAA was designed for the privacy of patients who are under the care of physicians. This form will allow us to release information and/or records to anyone specific, other than your insurance company. In addition to the insurance company, I authorize to the release of my medical records to:

Primary Care Physician______________________________

Spouse______________________________

Family Member______________________________

Coach/Trainer______________________________

Adjuster (Worker's Comp only)______________________________

Nurse Case Manager (Worker's Comp only)______________________________

Other (Please specify)______________________________

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I understand that I have the right to revoke this consent. I understand that if I would like to make changes to this form, I must do so in writing.

______________________________ ______________________________
Signature of Patient Date

______________________________ ______________________________
Signature of Parent or Legal Guardian if patient is minor/indigent Date