

CAROLINA ORTHOPEDICS & SPORTS MEDICINE, INC.

HIPAA MEDICAL RECORD CONSENT FOR PROTECTED HEALTH INFORMATION

I, _____ (date of birth _____), give Carolina Orthopedics & Sports Medicine, Inc. permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive from Carolina Orthopedics & Sports Medicine, Inc.

This consent is valid until such time as I provide Carolina Orthopedics & Sports Medicine, Inc. written revocation of it.

Carolina Orthopedics & Sports Medicine, Inc. may speak with:

Name: _____ Phone number: _____

Relationship: _____

Name: _____ Phone number: _____

Relationship: _____

Name: _____ Phone number: _____

Relationship: _____

Name: _____ Phone number: _____

Relationship: _____

Name: _____ Phone number: _____

Relationship: _____

RESTRICTIONS

May we call you at work?	Yes _____	No _____	N/A _____
Leave a message on your answering machine?	Yes _____	No _____	N/A _____
Send an appointment reminder?	Yes _____	No _____	N/A _____
Call on a cell phone? _____	Yes _____	No _____	N/A _____

Any other Restrictions?

Patient's signature: _____ Date: _____

Carolina Orthopedics & Sports Medicine, Inc. Employee: _____ Date: _____

Restrictions accepted by COSM Yes _____ No _____ N/A _____

I _____ request and authorize Carolina Orthopedics & Sports Medicine, Inc. to appeal any claims on my behalf, should my insurance company fail to pay my claim in full. They have my permission to submit my medical records on my behalf.

Patient's signature: _____ Date: _____