



Patients Name: _____

D.O.B.: _____

Authorization for Guests to be present during examination:

I hereby authorize the physician to speak freely during my examination and discuss personal health information as necessary of the following individuals. This discussion may include information regarding psychiatric and communicable diseases. I understand that at any time during this conversation, I have the right to ask my guest to step out of the room. This authorization will remain in effect for one year from the date of signature unless revoked in writing.

Name(s) of Authorized Guests:

The Sports Medicine Clinic of North Texas and/or members of the office staff may discuss and/or release your Protected Health Information to the following persons: (please circle one)

You: YES NO

Specified Other Persons: YES NO

If yes, specify to whom this information may be released:

Authorized Persons

Phone

Relationship

Protected Health Information may also be released in the following manner: (Please circle)

YES NO	Left on home/mobile voicemail (phone#)	_____
YES NO	Left on office voicemail (phone#)	_____
YES NO	Mailed to address provided (address)	_____
YES NO	Discussed directly over the phone (phone#)	_____
YES NO	Faxed (fax#)	_____
YES NO	Via e-mail (e-mail address)	_____

I give consent to be contacted by mobile phone or e-mail to verify my account information, payment information, account balance, lab results, X-ray/Diagnostics results, medications, medical status, appointment reminders, and other necessary information that I may need concerning my account.

Print name of Patient, Parent, Guardian: _____

Signature of Patient, Parent, Guardian: _____

Date: _____