ORTHOPEDIC INSTITUTE
810 E. 23rd Street, P.O. Box 5116 • Sioux Falls, SD 57117-5116
(605) 331-5890 • (888) 331-5890

Authorization to Discuss Treatment

Patient Name: _____ Date: _____
Chart: _____ Physician: _____

There may be occasions when you want to give another person the ability to discuss your care at Orthopedic Institute with Orthopedic Institute personnel (appointments, billing, treatment, prescriptions, etc.).

Examples could include spouse, parent (if you are over 18), another family member, adult-child, coach, nursing home representative, care provider, etc. This authorization will allow discussion only. This does not authorize release of medical records.

I give my permission for Orthopedic Institute personnel to share information verbally regarding my treatment at Orthopedic Institute with the following person(s):

Name: _____ _____
Relationship

Name: _____ _____
Relationship

Name: _____ _____
Relationship:

For additional names, please list on back

There will be occasions when Orthopedic Institute needs to contact you to discuss your care. I give Orthopedic Institute permission to contact me by phone at the following numbers:

Home: _____ Leave Message? Yes ☐ No ☐
Work: _____ Leave Message? Yes ☐ No ☐
Cell: _____ Leave Message? Yes ☐ No ☐

I give my permission for Orthopedic Institute personnel to leave messages regarding appointments, treatment, etc. and to release verbal information as indicated above.

Patient Signature: _____ Date: _____

For Staff Use Only: Permission via phone call

Verbal permission given to: _____ _____
(Employee) (Date)