ORTHOPAEDIC TRAUMA SPECIALISTS

Michael H. Handy, M.D., *Orthopaedic Surgeon*
Kevin P. Haddix, M.D., *Orthopaedic Surgeon*
Keith W. Paul, PA-C, *Physician Assistant*
Michael J. Jeffery, PA-C, *Physician Assistant*
Sarah A. Yacobi, PA-C, *Physician Assistant*

PATIENT CONSENT

By signing this consent you give ***Orthopaedic Trauma Specialists*** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. Your information will be used and disclosed to provide your care and treatment. In addition, your information will be used and disclosed to bill and collect payment for services provided and to perform necessary routine office operations.

I authorize ***Orthopaedic Trauma Specialists*** to release and discuss my health information with the person(s) listed below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have reviewed the "**Notice Of Privacy Practices"** regarding the release and use of my medical information covered under this consent. I understand that I may request a copy at any time. I understand that to revoke this authorization, I **must** submit my request in writing to ***Orthopaedic Trauma Specialists***.

Patient Name **(PLEASE PRINT)**:_____

Patient Signature **(OR RESPONSBILE PARTY)**:_____

Date:_____

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