Greater Hartford Orthopedic Group

HIPAA RELEASE FORM

Patient Name: _____ Medical Record #: _____

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information and account balances.

Name	Relation	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization will expire on: ____/____/____ (fill in date if less than 1 year) or one year after being signed.

_____ _____

Patient Signature Date