



**CONSENT FOR COMMUNICATION
OF PROTECTED HEALTH INFORMATION
TO PERSONAL REPRESENTATIVES**

Name:	
Address:	
City, State, and Zip:	
Telephone Number:	
Date:	

I, _____, give my written consent for Orthopedic Associates of SW Ohio, Inc. to share information regarding my protected health information and care to the following listed persons; I understand that these persons may be treated as personal representatives of myself.

Personal Representatives that you may share my health information with:

_____	(Name)	_____	(Relationship)
_____	(Name)	_____	(Relationship)
_____	(Name)	_____	(Relationship)

You may leave a message: (please check all that apply)

At Home At Work On answering machine

Verification Data: _____
(mother's maiden name or other id we can use)

_____	Patient's Signature	_____	Witness' Signature
_____	Date	_____	Date

Do not discuss my information with anyone other than myself at any time.
*(Must complete "Request for Confidential Communication of Protected Health Information" form.)