Chart No. ____________________________

Oklahoma Sports Science and Orthopaedics

Authorization to Release Information via phone / Family / Friends

Patient Name: ____ **DOB**: _______________

I hereby authorize confidential communications from the physicians or staff of OSSO regarding my health, care, treatments, appointments, prescriptions, etc… to be received at any of the numbers given below. I authorize the staff to leave messages on the voice mail or with the individual who answers the phone at any of the below numbers:

Home: ________________________ **Work**: ________________________ **Cell**: ________________________

Other: ________________________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested.

Name: ____ **Relation**: ____________________________

Name: ____ **Relation**: ____________________________

Name: ____ **Relation**: ____________________________

Name: ____ **Relation**: ____________________________

I understand this authorization will remain in effect until I revoke the authorization in writing.

____ ______________________

Patient Signature **Date**

OSSO STAFF ONLY
Documented by:

___________________ ____________________

Initials Date