John. R Budden, M.D.

A Professional Medical Corporation

Orthopedic Surgery
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

As required by HIPPA, you have the right to request that communications concerning your personal health information be made through confidential channels. Periodically, we will need to contact you for appointment reminders, to give test results, or to speak with you regarding any insurance/billing concerns. Please assist us in providing the proper means to contact you, and if you are not available, the name(s) of those you give permission to speak with.

I hereby authorize John R. Budden, M.D. to leave detailed messages regarding my personal health information via:

Home Telephone Number ☐Yes ☐No Phone #_____
Cell Phone Number ☐Yes ☐No Phone #_____

I hereby request and authorize John R. Budden, M.D. to disclose any medical information relating to diagnoses, care, treatment, test results and prognosis concerning myself to the individuals listed below. (*This may include spouses, relatives, children, friends, etc.)* I understand information may be either obtained in person, writing or by telephone. (*Write "None" in the space provided below if you do not want anyone to have access to your medical information*). This consent is valid until revoked in writing.

Name	Relationship to Patient	Telephone (if different than the Home Number above)

_____ _____
Patient Name (Printed) Signature of Patient/Legal Guardian

_____ _____
Legal Guardian Name (If applicable) Date