Sports Occupational & Knee Surgery, P.A.

Peter F. Holmes, M.D.
Diplomate of American Board of Orthopaedic Surgery
Fellow American Academy of Orthopaedic Surgery

Kathren Mccarty DPM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date _____

Pt Name _____ DOB _____ Acct # _____

HIPAA allows this office to release information to insurance companies and other entities as required to do business every day operations. We understand that some patients would like to authorize other persons to discuss pertinent information about patient's care with Sports Occupational & Knee Surgery, P.A. staff. For your convenience, we are providing this form for you to fill out.

I authorize the following person(s) to receive health care information about me.

Name _____ Relationship _____ Term Date _____

Name _____ Relationship _____ Term Date _____

Name _____ Relationship _____ Term Date _____

Name _____ Relationship _____ Term Date _____

Name _____ Relationship _____ Term Date _____

Name _____ Relationship _____ Term Date _____

SIGNATURE _____

This authorization is in effect until terminated by the patient or Sports Occupational & Knee Surgery, P.A.

Notes: _____

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