HOUSTON Methodist SM
ORTHOPEDICS & SPORTS MEDICINE

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

I, _____ **give** permission for *Houston Methodist Orthopedics & Sports Medicine* to disclose relevant health information (my health status, treatment, & payment arrangements) to my family members & the individual(s) I have listed below:

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

_____ _____

Signature of Patient or Qualified Representative* Date

*In the event the patient is unable to sign, please print the name of the Patient's Qualified Representative & the legal authority to act on behalf of the patient.

_____ _____

Name of Qualified Personal Representative Legal Authority on Behalf of Patient

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Primary **C**are **P**hysician: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Lab Preference: _____