Paul Phillips III, MD

AUTHORIZATION FOR MINOR'S TREATMENT

Child's full Legal Name:____

Date of Birth:_____Age_____Gender_____

Doctor:____________________

Authorization and Consent fo Parent(s) or Legal Gaurdian(s)

I have legal custody of the aforementioned minor child.

I grant my authirization and consent for Dr____________________
to administer treatment for the injury experienced by the minor.

It is understood that authorization is given in advance of any such medical treatment, but is given to allow the physician to excercise his best judgement in the treatement of the minor in the office setting.

This authorization is effective commencing on________________,
and expiring on________________.

Signed on:________________by____________________________.
Signature of Parent or Legal Guardian

_________________________________ _________________________________
Name fo person accompanying minor Relationship

____
Signature of person accompanying minor

I authorize PHILLIPS ORTHOPEDIC ASSOCIATES to disclose certain protected health information (PHI) about me to (ex. Wife, doctor, children, etc...) Please list names and their relationship.

First and Last Name	Relationship
1)______________________________	______________________________
2)______________________________	______________________________
3)______________________________	______________________________
4)______________________________	______________________________

This authorization allows PHILLIPS ORTHOPEDIC ASSOCIATES to discuss the following information:

My treatment and care for (condition):

____

____

This authorization will expire on:______________________________________

(Expiration date or Defined Event)

I understand that I have the right to revoke this authorization at anytime, to the extent that PHILLIPS ORTHOPEDIC ASSOCIATES has taken action on it, by putting revocation in writing and signing and dating.

______________________________ ______________________________

Patient's Name Date Patients date of birth

______________________________ ______________________________

Patient's/Authorized Signature Relationship to patient (if minor)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:________________________ Date of Birth:________________________

DOB ________________________ SS #________________________

I hereby authorize____

Address____

Phone________________________ Fax________________________

To disclose the following protected health information to:

PHILLIPS ORTHOPEDIC ASSOCIATES

PAUL PHILLIPS III, MD

Phone: 830-990-0991 Fax: 972.764.8909

The information to be disclosed should be the following:

- ☐ Last 2 years of my medical record my physician thinks is appropriate
- ☐ Services related to the following________________________
____
- ☐ Information limited to dates of service________________

Reason for request:

- ☐ Medical Request (continue care)
- ☐ Health Insurance Request
- ☐ Life/Disability Insurance Request
- ☐ Personal Request
- ☐ Other Request
- ☐ Legal Request
- ☐ Transferring Care

Do *NOT* send any information related to:

☐ AIDS. ARC, or HIV ☐ Alcohol or Drug Abuse ☐ Mental Health Disorder

This authorization shall be in force and until

- ☐ Revoked by me
- ☐ The following specific date:________________
- ☐ One year after signature date at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to: Phillips Orthopedic Associates. I understand that a revocation is not effective to the extent that Phillips Orthopedic Associates has already relied on this authorization to use and disclose the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to the re-disclosure by the recipient and may no longer be protected by federal or state law.

____ ____

Signature of Patient or Personal Representative Date