

TIER ORTHOPEDIC ASSOCIATES
100 PLAZA DRIVE
VESTAL, NY 13850

Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

PATIENT NAME: _____ DOB: _____

Leave appointment and billing messages on/with: Leave medical information messages on/with:

Answering machine?	___ Yes	___ No	Answering machine?	___ Yes	___ No
Office Voice Mail?	___ Yes	___ No	Office Voice Mail?	___ Yes	___ No
With another person?	___ Yes	___ No	With another person?	___ Yes	___ No
Send through the mail?	___ Yes	___ No	Send through the mail?	___ Yes	___ No
Send via email?	___ Yes	___ No	Send via email?	___ Yes	___ No
Cell Phone?	___ Yes	___ No	Cell Phone?	___ Yes	___ No

If you answered YES to allowing us to discuss your appointment, billing and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name:	Relationship:	Phone:	Cell Phone:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional HIPAA Contact instructions:

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: _____

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP: _____

DATE: _____