



ORTHOPEDIC & SPORTS MEDICINE CENTER OF GARLAND

I have been presented with a copy of Orthopedic and Sports Medicine Center of Garland's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my personal medical information:

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

I have read and understand the **Medication Policy** that has been given to me.

Signed: _____ **Date:** _____

I hereby authorize the doctors and staff of Orthopedic & Sports Medicine Center of Garland to furnish information to insurance carriers and/or outside medical suppliers necessary for my continuity of care concerning my illness, accidents and treatment; and I hereby assign to the doctors all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

A photocopy of this authorization and assignment shall be considered as valid as the original.

Signature of Patient or Responsible Party: _____

Date: _____