PHONE MESSAGE and CONTACT AUTHORIZATION

Patient Name_____ Date of Birth___/____/____

The doctors and staff of Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd. have my permission to leave messages containing medical and/or financial information on my answering machine.

HOME: Yes___ No___ BUSINESS: Yes___ No___

Note: If permission is not granted, only the date, time and location of your appointment will be left on your answering machine.

I give authorization for the following people to discuss my medical and/or financial information with doctors and staff of Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd.

NAME **RELATIONSHIP** **PHONE#**

(1)_____

(2)_____

(3)_____

Signature of Patient_____ Date_____

Signature if Patient's Authorized Representative____ _____ Date_____

Name of Patient's Authorized Representative_____ Date_____

I understand that Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd. originates and maintains protected health information for the purposes of treatment, payment and health care operations as explained below:

- Treatment includes activities performed by a health care provider, practitioner, office staff and other health care professional providing care, coordinating or managing care with third parties and consultations with other health care providers. This consent also includes any practitioner who provides coverage for MWSM by telephone as the on call practitioner.
- Payment includes activities involved in making a determination of eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities that may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
- Health care operations include the necessary administrative and business functions of MWSM.

By initialing at the end of this paragraph, I acknowledge that I have received a copy of the MWSM Notice of Privacy Practices (NPP). I understand this document provides additional information about the use/disclosure of my protected health information. INITIAL HERE_____