BLOUNT ORTHOPAEDIC ASSOCIATES

Kenneth C. Berg M.D.
John T. Kroner M.D.
Joseph M. Kroner M.D.
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Rory R. Wright M.D.
Dean W. Ziegler M.D.

I, _____ Date of Birth_____Chart# _____
(PRINT-Patient's FULL Name)

AUTHORIZE: ALL PHYSICIANS AND STAFF OF BLOUNT ORTHOPAEDIC ASSOCIATES, S.C.

TO DISCUSS MY MEDICAL TREATMENT AND CONDITION WITH:

(Please check all that apply - PRINT name(s))

❑ Patient's spouse:_____ ❑ Patient's Children_____

❑ Patient's parent(s):_____ _____

_____ _____

❑ Patient's Legal Guardian(s):_____ ❑ Other (Specify name and Relationship) _____

_____ _____

PURPOSE OF DISCLOSURE IS TO: **Allow discussion of my medical treatment and condition.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***ONE YEAR*** AFTER I CEASE MEDICAL TREATMENT WITH BLOUNT ORTHOPAEDIC ASSOCIATES, S.C.

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TO DISCUSS PERTINENT FINANCIAL/ACCOUNT INFORMATION WITH:

(Please check all that apply - PRINT name(s))

❑ Patient's spouse:_____ ❑ Patient's Children_____

❑ Patient's parent(s):_____ _____

_____ _____

❑ Patient's Legal Guardian(s):_____ ❑ Other (Specify name and Relationship) _____

_____ _____

PURPOSE OF DISCLOSURE IS TO: **Allow discussion of my pertinent financial / account information.**
THIS AUTHORIZATION IS EFFECTIVE FOR ***TWO YEARS*** FOLLOWING SATISFACTION OR PAYMENT OF ALL BALANCES OWED BLOUNT ORTHOPAEDIC ASSOCIATES, S.C.

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You may refuse to sign this authorization. You have the right to revoke this authorization at any time in WRITING. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to your insurance company when the law provides your insurer with the right to contest a claim under your policy. The information disclosed may be subject to redisclosure by the recipient and no longer protected by law. Treatment, payment, enrollment in a health plan or eligibility for benefits is not based on the provision that you sign this authorization. You will be given a copy of this authorization.

_____ _____
Signature of Patient or Other Legally Authorized Person Date of Signing

_____
If signed by Other Legally Authorized Person, indicate Relationship to Patient