



**PERMISSION TO GIVE OUT INFORMATION**

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information.

I, \_\_\_\_\_ hereby grant the physicians and staff of Orthopaedic & Sports Medicine at Cypress, LLC my permission to speak with the following people my health and well being. Effective Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone #'s: \_\_\_\_\_  
Home Work Cell

The following information may be given to the above individual:

- 1. Appointment Time
- 2. Financial Information
- 3. Test/Lab Results
- 4. Medications
- 5. Procedures
- 6. Other information regarding my Health

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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone #'s: \_\_\_\_\_  
Home Work Cell

The following information may be given to the above individual:

- 1. Appointment Time
- 2. Financial Information
- 3. Test/Lab Results
- 4. Medications
- 5. Procedures
- 6. Other information regarding my Health

I understand I may revoke this consent at any time by giving written notice to Orthopaedic & Sports Medicine at Cypress.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_