PATIENT AUTHORIZATION FORM

PATIENT NAME:_________________________________ **DATE OF BIRTH:** _____________

I. Authorization To Use and Disclose Health Information

I have read and understand Bienville Orthopaedic Specialists, LLC Notice of Privacy Practices. I authorize Bienville Orthopaedic Specialists, LLC, to use and disclose the specific health and medical information regarding my treatment for the purposes described to my insurance company, my Primary Care Physician and other Health Care Providers. I acknowledge that I am responsible for providing and updating my insurance, demographic, Primary Care Physician as well as other Care Providers to Bienville Orthopaedic Specialists.

II. Permission To Give Medical Information

I hereby authorize the physicians and staff of Bienville Orthopaedic Specialists, LLC to give information concerning my health and well being to the person(s) listed below. Including, appointment times, test/lab results, medication, procedures and any information regarding my health.

1. ____ ______________________________
(Full Name) **(Relationship)**

2. ____ ______________________________
(Full Name) **(Relationship)**

3. ____ ______________________________
(Full Name) **(Relationship)**

III. Message/Answering Machine

I hereby authorize Bienville Orthopaedic Specialists, LLC, to leave a message on the answering machine/voice mail at:

____
(Area Code + Phone Number)

IV. Financial

I hereby assign, transfer and set over to Bienville Orthopaedic Specialists all my interest to medical reimbursement benefits under my insurance policy. Furthermore, I attest that I have provided accurate and reliable insurance information to Bienville Orthopaedic Specialists; and regardless of insurance coverage, I acknowledge that I am financially responsible for all services provided to me by Bienville Orthopaedic Specialists.

Signed: ____ **Date:** _______________
(Patient / Parent / Legal Guardian/Representative)

Revised 6-10