1000 Northern Blvd
Suite 110
Great Neck, NY 11021
516-325-7240

I, ______________________________, (☐do / ☐do not) give permission for any staff member of **NSLIJ Orthopaedic Institute and its Physicians,** to speak with a family member or individual regarding appointments, prescriptions, test results or pick up films on your behalf. Please list the individuals that we may speak with:

Name ______________________________ Relationship ______________
Name ______________________________ Relationship ______________
Name ______________________________ Relationship ______________

May we leave a voice mail recording regarding your appointment or a message to call us back?
☐Yes ☐ No

______________________________ ______________________
Patient Signature **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct my physician(s), having treated me, to release to other treating physicians, government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

______________________________ ______________________
Patient Signature **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION VIA E-MAIL

By providing your email address, you agree to receive by email address information about your healthcare, including protected health information.

______________________________ ______________________
Patient Signature **Date**

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to my physician(s), sufficient monies and/or benefits I may be entitled from government agencies, insurance carriers, or others who are financially liable for medical costs of the care and treatment rendered to me or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

______________________________ ______________________
Patient Signature **Date**

I have been informed that the **NSLIJ Orthopaedic Institute** is HIPAA compliant and a copy of the "Notice of Privacy Practice" is available for my perusal.

______________________________ ______________________
Signature of Patient or Personal Representative **Relationship to Patient**

______________________________ ______________________
Print Name of Patient or Personal Representative **Date**