



**NORTH SHORE
ORTHOPAEDICS**
S.C.

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GLENDALE OFFICE • 7545 N PORT WASHINGTON RD • GLENDALE, WI 53217-3422
(414) 351-3500 • FAX (414) 351-9063

I _____ Date of Birth: _____ Chart No.: _____
(PRINT - Patient's Full Name)

AUTHORIZATION FOR CONSULTATION

AUTHORIZE: ALL PHYSICIANS AND STAFF
(Name of Party Authorized to Consult)

North Shore Orthopaedics, S.C.
7545 North Port Washington Road
Glendale, WI 53217-3422

Patient's Parent(s): _____

Patient's Legal Guardian(s): _____

TO DISCUSS MY MEDICAL TREATMENT AND CONDITION
WITH (please check all that apply). Please PRINT names(s)

Patient's Spouse: _____

Other (Specify): _____

Patient's Child(ren): _____

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 at North Shore Orthopaedics, S.C.

AUTHORIZATION FOR RELEASE OF FINANCIAL/ACCOUNT INFORMATION

AUTHORIZE: NORTH SHORE ORTHOPAEDICS, S.C.
7545 NORTH PORT WASHINGTON ROAD
GLENDALE, WI 53217-3422
(Name of Party to Release Financial Information)

Patient's Parent(s): _____

Patient's Legal Guardian(s): _____

TO DISCUSS PERTINENT FINANCIAL/ACCOUNT
INFORMATION WITH (please check all that apply). Please PRINT name(s)

Patient's Spouse: _____

Other (Specify): _____

Patient's Child(ren): _____

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 North Shore Orthopaedics, S.C.

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, Relationship to Patient)

RETURN WHITE COPY TO: NSO/Chart Notes _____
(Employee Initials)