Patient Permission Form

CT. Orthopaedic & Hand Surgery Center
5 Founders St, Suite 202
Willimantic, CT 06226
Ph. 860-456-3997 Fx-860-450-7323

I _____ give permission for CT Orthopaedic & Hand surgery Center to discuss my medical information with the following people.

Name	Relationship	Phone Number	Patient Initials

I also give permission for CT Orthopaedic & Hand Surgery Center to leave messages regarding medical/billing information on my answering machine. YES _____ NO _____

FOR DEPENDENT STUDENTS, OVER 18 YRS. OF AGE AND COVERED UNDER PARENTS/GUARDIAN'S INSURANCE POLICY.

I _____ give permission for CT Orthopaedic & Hand Surgery Center to discuss my billing/medical information with my parents and/or policy holder(s).

Name	Relationship	Phone Number	Patient Initials

Patient Signature _____ **Date** _____

DLH-09/10