Authorization & Consent For Release of Information:

This form allows Motion Orthopaedics to release records from our office, discuss medical treatment and/or any billing issues with the following people:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

May we leave a voicemail message on your phone? ☐ Yes ☐ No
If Yes, Check all that apply: ☐ Cell ☐ Home ☐ Work

May we Text your Cell? ☐ Yes ☐ No

May we call your cell regarding billing issues? ☐ Yes ☐ No

Signature: _____ Date: _____

☐ By checking this box I affirm my intent to sign this form electronically by typing my name above