



Tri-County Orthopaedic & Sports Medicine, P.A.
 160 Hanover Avenue • PO Box 1446 • Morristown, New Jersey 07962-1446
 Voice: (973) 538-2334 • Billing: (973) 538-0329
 Fax: (973) 829-9174 • RX Line: (973) 989-6317

Mark J. McBride, MD, FAAOS
 Robert T. Goldman, MD, FAAOS
 Wayne A. Colizza, MD, FAAOS
 Michael I. Goldberger, MD, FAAOS
 Paul M. Lombardi, MD, FAAOS
 Charles A. Gatto, MD, FAAOS
 Andrew A. Willis, MD
 Kenneth D. Montgomery, MD
 Claudia L. Ginsberg, MD
 Alena Polesin, MD
 Peter Tsairis, MD, FAAN

CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
 For the TREATMENT, PAYMENT or HEALTHCARE OPERATIONS

I _____ understand that as part of my treatment, Tri-County Orthopaedic & Sports
 Print Name

Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- As basis for planning my care and treatment
- A means of communication among any other health care professionals who might contribute to my care, i.e.: via facsimile, telephone, etc
- A source of information for applying diagnosis and surgical information to my account to process for payment
- A means by which a third-party payer can verify that services billed are accurate and actual
- And as a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials

I understand Tri-County Orthopaedic & Sports Medicine, Inc. will take great care to insure that any and all information pertaining to me, and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the even of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent that the organization has already acted in.

- I authorize Tri-County Orthopaedic and Sports Medicine, Inc. to release my medical records to the following:

- I request the following restrictions to the use, or disclosure of my health information:

Print Name of Patient of Legal Guardian

Signature

Date