UNOVA HIP&KNEE CENTER

539 Rolling Acres Rd | Lady Lake, FL 32159
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Authorization to Disclose Health and Billing Information

This authorization disclosure form covers all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing UNOVA Health in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by UNOVA Health.

Authorization for Medical Information Disclosure

I authorize UNOVA Health to release any information regarding my treatment; including lab results, x-rays, and medical records to the following individuals/entities (UNOVA Health may not release information or records to the names individuals/entities unless you identify them here):

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Authorization for Financial Information Disclosure

I authorize UNOVA Health to release any information regarding my financial and billing information; including balances pending or due, and insurance information to the following individuals/entities (UNOVA Health may not release information or records to the names individuals/entities unless you identify them here):

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that UNOVA Health will use my home phone number and primary address supplied during registration to contact me regarding my financial, billing information, and/or treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

_____ _____

Patient/ Legal Guardian Signature Today's Date

_____ _____ _____

Patient FirstName (Print) Patient LastName (Print) Patient Date of Birth

_____ _____

*Patient Representative Name (Printed) *Relationship to Patient

(Required if the patient is a minor or if the patient is unable to sign this form.)