



FREDERICK G. LOCHER, M.D., S.C. *
 MICHAEL P. YOUNG, M.D., S.C. *
 MARK S. GROSS, M.D., S.C. *
 DAVID E. NORBECK, JR., M.D., S.C. *

JACK B. PERLMUTTER, M.D., S.C. *
 CRAIG A. CUMMINS, M.D., S.C. *
 GREGORY T. BREBACH, M.D., S.C. *
 DAVID M. ANDERSON, M.D., S.C. *

In Association With:
 DAVID S. SCHNEIDER, D.O., S.C. **

Lake Cook Orthopedic Associates

27401 West Highway 22 • Suite 125 • Barrington, Illinois 60010 • (847) 381-0388 • Fax (847) 381-0811
 www.lakecookorthopedics.org

PATIENT INFORMATION AUTHORIZATION

I, _____, authorize the methods of communication of my protected health information (PHI) as indicated below. I understand that under HIPAA guidelines my patient information is held confidential unless authorized by my signature.

The following person(s) may inquire, retrieve records, prescriptions, etc. and receive messages regarding my health information:

- 1) _____ Relationship: _____ Tel: _____
- 2) _____ Relationship: _____ Tel: _____
- 3) _____ Relationship: _____ Tel: _____
- 4) _____ Relationship: _____ Tel: _____

The physicians and staff of **LAKE COOK ORTHOPEDIC ASSOCIATES** are authorized to communicate PHI such as test results, messages or appointment information. Please initial each appropriate line you wish to authorize:

- _____ Telephone Answering Machine
 _____ With person(s) listed above
 _____ Mail to: () Home () Office
 _____ Fax Machine: Fax # _____

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____
 (Signature of Parent or Legal Guardian if patient is a minor)

Print Name of Parent or Legal Guardian if applicable: _____