**HVMG ORTHOPEDICS**

**Casey R Antholz, DO**

**Carolyn P Engle, MD**

**Andrew S Kaye, MD**

**John D Lehman, MD**

**Alexis E Pilato, MD**



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REQUESTED RESTRICTION ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM (PHI)

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to Heritage Valley Medical Group Orthopedics to leave information on your voice mail. I understand this may pertain to medical information.

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Signature Date

I also give permission for the following people to be given information and/or bring a minor in for treatment:

 Name Relationship

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Right to revoke: You make revoke this authorization at any time except to the extent that we have relied on this authorization. To revoke this authorization, you must submit a written revocation to our Privacy Policy Officer at the following address: Andrew S Kaye, MD, 1030 Beaner Hollow Road, Beaver, PA 15009.

**.**

**Beaver Medical Commons**

**1030 Beaner Hollow Road • Beaver, PA 15009 • 724-775-4242 • Fax 724-775-4960**