

# ***Orthopaedic Trauma Specialists***

***Michael H. Handy, MD***

3515 W. Market Street, Suite 110

Greensboro, NC 27403 (336) 299-0099

I have read the privacy notice regarding the release and use of my medical information and I authorize ***Orthopaedic Trauma Specialists*** to release my information to (this includes friends and/or family to pick up and medical information at our office, have it faxed to them, or inform them of upcoming appointments):

Name and Relationship to Patient:

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I understand that to revoke this authorization, I **must** submit my request in writing to ***Orthopaedic Trauma Specialists***.

Patient Name: \_\_\_\_\_

Patient Signature (Parent/Guardian if minor): \_\_\_\_\_

Date: \_\_\_\_\_