



## Release of Protected Health Information

Western Slope Orthopaedics has my permission to release my personal information to the following people.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone# \_\_\_\_\_

Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_