

**Kansas City Bone & Joint Clinic, P.A.**

Account# \_\_\_\_\_  
(Office Use Only)

**Patient Name: (Please Print)** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Authorization to release Information:** I hereby authorize this facility to release my Protected Health Information to:

Check all that apply:

- None: \_\_\_\_\_
- Parents: \_\_\_\_\_ Phone: \_\_\_\_\_
- Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_
- Children: \_\_\_\_\_ Phone: \_\_\_\_\_
- Children: \_\_\_\_\_ Phone: \_\_\_\_\_
- Personal Representative: \_\_\_\_\_ Phone: \_\_\_\_\_
- Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_
- Others: \_\_\_\_\_ Phone: \_\_\_\_\_

**Sign Here** → Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Please check out our interactive website [WWW.KCBI.COM](http://WWW.KCBI.COM)