



St. Vincent's Orthopedics, P.C.

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I hereby authorize St. Vincent's Orthopedics, to furnish any information concerning my medical condition, treatment, prognosis, test results, and appointment dates and times to the following family members:

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

I do not want my information released to anyone.

May we mail your appointment reminders: Yes _____ No _____

I, _____,
understand that you will be transmitting my medical records electronically to my referring doctor, etc. and authorize you to do so. If another party receives them in error, I absolve Dr. David Adkison, Dr. Thomas Johnson, and Dr. Edward Kissel of any and all liability relating to such submission of said records.

Signature: _____ Date: _____
(Lifetime signature) (Parent signature if patient is minor)

Witness: _____ Date: _____