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## Consent to Release Information

I, \_\_\_\_\_, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends, or legal counsel with whom we are allowed to discuss your treatment or billing issues.)

\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ Relation: \_\_\_\_\_  
\_\_\_\_\_ *School* Trainer: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian Signature if a minor)

Patient Signature (2<sup>nd</sup> Annual): \_\_\_\_\_ Date: \_\_\_\_\_