CASCADE ORTHOPEDICS & SPORTS MEDICINE CENTER, P.C.
FRIENDS and FAMILY CONSENT

I attest that the individuals listed below are involved in my care or the payment of my care. Accordingly, I consent to providers and staff at Cascade Orthopedics & Sports Medicine Center, P.C. (Practice) sharing with them my health and related payment information to the extent it is relevant to their involvement in my care or payment for care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I am responsible for informing Practice of any changes to the information above, and that any changes must be communicated to Practice in writing.

_____ Date: _____, 20___
(Print patient name)

_____ _____
(Signature of patient or legal guardian) (Print guardian name)