



**Affix Patient Label**

**AUTHORIZED PATIENT NOTIFICATION LIST**  
(Required of HIPAA) Health Insurance Portability and Accountability

I authorize all Hughston Clinic Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my orthopedic care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

_____	_____
_____	_____
_____	_____

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

\_\_\_\_\_  
PATIENT/OTHER PERSON AUTHORIZED TO SIGN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATION TO ABOVE SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE