

PATIENT PREFERENCE – COMMUNICATION OF HEALTH INFORMATION

WHO TO CONTACT:

I hereby give permission to **Orthopedic Specialists** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ **DO NOT** wish to give permission for family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

HOW TO CONTACT:

I wish to be contacted in the following manner:

HOME TELEPHONE:

- OK to leave detailed medical information
- Leave message with call back number only

WORK TELEPHONE:

- OK to leave detailed medical information
- Leave message with call back number only

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have received and reviewed this office’s Notice of Privacy Practices, which explains how medical information will be used and disclosed.

Signature of Patient or Representative

Date

Name of Patient

Name and Description of Personal Representative, if Applicable