

Advanced Orthopedics

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972-964-2626

Patient Name: _____

Date of Birth: _____

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to Advanced Orthopedics 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

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

II. How to Contact

I wish to be contacted in the following manner:

Home/Cell Phone:

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

Work Phone:

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

OK to FAX written information to this fax number: _____

Patient Signature: _____

Date: _____