RELEASE OF INFORMATION
TO BE COMPLETED BY PATIENT

Please print the telephone number where you want to receive call about your appointments, labs, and x-ray results or other health care information. This may include surgery scheduling information, and post-operative instructions:

Home: _____ Cell: _____
(I am fully aware that a cell phone is not a secure and private line)

May confidential message (i.e. appointment reminders) be left on your answering machine or voicemail? Yes_____ or No_____

_____ _____
Signature of Patient or Legal Guardian Date

Please list the family members, significant others, or other persons, if any, whom we may inform about your general medical condition and your diagnosis. This may also include treatment plan, prognosis, payment information and health care options:

Name_____ Relationship_____ Phone_____

Please list family members, significant others, or other persons, if any, whom we may inform about your medical condition *ONLY IN AN EMERGENCY*:

Name_____ Relationship_____ Phone_____

NOTE: Uses and disclosures of health information may be permitted without prior consent in an emergency.

If unable to keep appointment, kindly give 24 hour notice during office hours. A charge may be applied for any un-cancelled appointments.
In the case of a third party liability injury, we do not correspond with any attorney, nor do we appear in court on your behalf. You may request to have your medical records copied by a copy service, which we will be happy to arrange for you. You will be responsible for the copy service fees. There is an additional charge to have x-rays copied. If your insurance requires that insurance forms be completed by us or your medical records copied and sent to them, there is a nominal charge for this service, which will be added to your account.

_____ _____ _____
Patient's Name (Please Print) Patient's Signature Date

South County Orthopedic Specialists
949-586-3200