Patient Name:____ Patient Identifier #:______________________________

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to North Texas Orthopaedic 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

__________I do not wish to disclose any information with anyone.

II. How to Contact

I wish to be contacted in the following manner:

Home Telephone:	Work Telephone:	Cell Phone:
[ ] OK to leave message with detailed information [ ] Leave message with call-back number only	[ ] OK to leave message with detailed information [ ] Leave message with call-back number only	[ ] OK to leave message with detailed information [ ] Leave message with call-back number only

[ ] Written Communication

- [ ] OK to mail to my home address______________________________________
- [ ] OK to mail to my work/office address__________________________________
- [ ] OK to fax to this number____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

____________________________________ ____________________________________

Signature of Patient or Legal Representative Date