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SPORTS INJURIES
ARTHROSCOPIC SURGERY

TOTAL JOINT REPLACEMENT
FRACTURES

PATIENT: _____

PLEASE CHECK THE ONE THAT APPLIES TO YOU:

_____ I give my permission to leave messages in regard to blood work results, outside testing, appointment changes, etc. Either on my answering machine or with a family member who answers my home telephone.

_____ If I am unable to be reached by phone, NO message pertaining to myself is to be left on my home answering machine or with a family member.

PATIENT'S SIGNATURE/DATE: _____ / /

This is to certify that I, _____, request that my medical information be only released to :(include any doctors you wish to have your medical information sent to).

Name(s) and Relationship:

_____

_____

_____

_____

_____ I do not want to have any of my health-related information released to any one other than myself.

PATIENT'S SIGNATURE/DATE: _____ / /

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