Joseph C. Tauro, M.D.

Assistant Professor of Orthopedic Surgery
New Jersey Medical School
Director, Ocean County Sports Medicine Center

Sports Injuries
Arthroscopic Surgery

Minimally Invasive
Joint Replacement

PATIENT NAME: _____

PLEASE CHECK THE **ONE** THAT APPLIES TO YOU

_____ I give my permission to leave a message 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 person, family, doctors, you wish to have your medical information sent to).

NAME(S):	**RELATIONSHIP:**
_____	_____
_____	_____
_____	_____
_____	_____

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

PATIENT'S SIGNATURE_____ DATE: _____

9 Hospital Drive **Toms River, New Jersey 08755** **(732) 341-6226**