AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

Patient's Name: ____

(***Please Print***)

I hereby give permission for The Orthopedic Sports Clinic to leave messages regarding office visits, surgery information and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s) and/or with the following individual(s):

(*Please check all that apply*)

__Home Answering Machine Phone Number: ___________________________

__Family Members (*Please list below*)

Name: ___________________________ Phone Number: ___________________________
Name: ___________________________ Phone Number: ___________________________
Name: ___________________________ Phone Number: ___________________________

__Housekeeper (*Please list below*)

Name: ___________________________ Phone Number: ___________________________

__Work Voicemail Phone Number: ___________________________

__Assistant (*Please list below*)

Name: ___________________________ Phone Number: ___________________________

__ Other (*Please list below*) Phone Number: ___________________________

__ I DO NOT give my permission to The Orthopedic Sports Clinic to leave any medical information related to my condition to anyone other than myself in a direct manner. Please call me at the following phone number: ____.

____ ______________________________

Signature **Date**

Relationship: __Self
__Parent or Legal Guardian
__Other:______________________