

Orthopaedic Specialists at Raulerson

Whom to Contact

Patient's Name: _____ **Date of Birth:** _____

Emergency Contact

Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency.

Name: _____

Relationship to Patient: _____

Cell #: _____ Home #: _____

Identification of Parent Substitute

I hereby give permission to Orthopaedic Specialists at Raulerson to obtain access to Protected Health Information, give informed consent for care and treatment, disclose and discuss any information related to patient's medical condition(s) to/with the following family member(s), other relative(s) and/or close person friend(s):

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

Name: _____ **Relationship:** _____ **Phone Number:** _____

I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my child's medical condition(s).

I wish to be contacted in the following manner: Cell # _____ Home # _____

- Ok to leave a message with detailed information at home
- Ok to leave a message with call back number only at home
- Ok to leave a message with detailed information at work
- Ok to leave a message with call back number only at work

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 request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Signature of Patient's Responsible Party/Legal Guardian: _____ **Date:** _____