Center for Orthopaedic Surgery and Sports Medicine
7940 FLOYD CURL DRIVE SUITE 560 • SAN ANTONIO, TX 78229
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PERMISSION TO SHARE HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name _____ DOB _____

By signing this paper below, I give permission to the person(s) listed in the table below to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care or financial responsibility. Any information requested that does not pertain to assisting with my health care or financial responsibility and any requests for copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	Comments/Instructions (i.e.: may pick up meds, may disclose test results, etc)	Patient/Guardian Initial

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

[ ] Leave message at home with my spouse/partner/child or other family member

[ ] Leave message on cell phone. Cell phone number:_____

[ ] Leave message at work. Work phone number:_____

[ ] Leave a message on voicemail. Phone number:_____

[ ] Leave a detailed message on answering machine: Phone number:_____

_____ _____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian Relationship (if not self)