Fort Pierce Orthopaedics, LLC

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 Fort Pierce Orthopaedics, LLC 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:** ___________