The Centers for Advanced Orthopaedics
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# Private Health Information Release Form

Patient Name: _____ Date of Birth: _____/_____/_____

## Release of Information

( ) I authorize the release of information, clinical and financial, to the following:

( ) Spouse _____

( ) Child/ren _____

( ) Other _____

( ) Information is **NOT** to be release to anyone.

## Messages

Please call: ( ) my home ( ) my work ( ) my cellphone

If unable to reach me: ( ) you may leave a detailed message
( ) leave a message requesting a return call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____