DMOS ORTHOPAEDIC CENTERS

Communications Form

Patient name: _____
(please print)

Date of birth: _____ (mm/dd/yyyy)

Release of Information:

- ❑ I do not want any other person to have access to my appointments and medical care.
- ❑ I give permission for the following person(s) to receive information regarding my appointments and medical care.

Note: Release of medical records requires a separate form from this one.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

How can we contact you?

You may leave a message on my: __Home answering machine __Cell Phone __ Work voice mail
[Note: Medical information will not be left on unidentified answering machine / voicemail.]

You may call me at: __Home __Cell __Work

You may leave an appointment reminder message via (choose at least one):
___Text ____ E-mail ____None

Email address _____

I understand I may revoke this communication form at any time by sending written notice to the office.

This authorization does not provide the above named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.

Patient or guardian signature_____Date:_____

Relationship if not patient_____