Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

Patient Name: ____

Date of Birth: ____

Consent to be Contacted

We, or third parties on our behalf, may need to contact you regarding your healthcare or your account with us. Those communications may include appointment and exam confirmation and reminders, wellness checkups, pre-registration instructions, pre-operative instructions, post-discharge instructions, post-appointment follow-up, prescription notifications, and other messages relating to your care, scheduling, benefits, billing, payment, or other financial responsibilities. By providing your phone number, you agree to receive calls or text messages from us, or a third party on our behalf, at the number you have provided. Such calls may be placed using an automatic telephone dialing system.

Please provide your preferred contact information below:

Name of Person to Contact: ____

Cell Number: ________________________________ **Home Number:** ____________________________

Designation of a Person Involved in Patient's Care

A patient may designate a person who is involved in their care. This person may be a spouse, adult child, members of the patient's family, or close friend. They may also be any individual, with Healthcare Power of Attorney, or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. With respect to a minor child, this person's their parent or legal guardian.

The people designated below may receive information that otherwise would be given to the patient. Such information could include appointment changes, messages regarding surgery and/or testing, physician's responses to phone messages and medication requests. A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.
Please note: This form does not grant permission to release medical records to those designated below.

Person(s) to whom my information may be disclosed:

Name	Relationship	Phone Number
____________________	____________	____________
____________________	____________	____________
____________________	____________	____________

X **Signature:** ____ **Date:** ____________________

If the patient is a minor:

Mother's Name ________________________________ and **Father's Name** ________________________________

or Legal Guardian's Name ___________________________________