

**PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION**

I, \_\_\_\_\_, am requesting that Aspen Orthopedics communicates future information regarding my healthcare  
(Print Patient's Name)

to me in the following manner:

Mail invoices or statements to (If other than home address): \_\_\_\_\_

**Permission to discuss health information with other individuals**

Please list the names of individuals with whom we may discuss your health information:

Name (first and last):	Relationship:	Phone Number:	H/W/C*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

\*NOTE: Please indicate if phone number (above) is home, work or cell by marking H, W or C.

May we leave a message on your answering machine at home:  Yes  No  N/A

May we leave a message on your cell phone:  Yes  No  N/A

May we leave a message on your answering machine at work:  Yes  No  N/A

Work number to leave a message: \_\_\_\_\_

By submitting this form, I hereby grant permission to the staff at Aspen Orthopedics staff to discuss my health information with the people listed above.

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

If the patient is a minor or has a legal representative:

I represent that I am the legal parent/guardian/personal representative of the patient named above:

Signature of Legal Representative: \_\_\_\_\_

**YOU MUST PRINT THIS FORM OUT AND BRING IT WITH YOU TO YOUR APPOINTMENT.  
THIS FORM DOES NOT AUTOMATICALLY GET SENT TO ASPEN.  
IF YOU DO NOT PRINT THIS FORM OUT, THE INFORMATION WILL BE LOST.**