aspen
ORTHOPEDIC SPECIALISTS
Experience. Excellence.

Phone - **262/395-4141**

Brookfield - 19475 W. North Avenue, Suite 201
Brookfield PT – 2205 N. Calhoun Road, #17
New Berlin - 12555 W. National Avenue, Suite 100

www.aspenors.com

Date:_____

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.

z: 00 forms\Patient Request for Confidential Communication form - 11/14/13 lmc, 11/18/13 lmc, 1/27/16 lmc
Scan: Patient/Aspen Orthopaedic & Rehab Specialists1/Patient Contact Form