Date:_____

aspen
ORTHOPEDIC SPECIALISTS
Experience. Excellence.

Phone - **(262)395-4141**

www.aspenors.com

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____ (print patient's name), am requesting that Aspen Orthopedic Specialists communicates future information regarding my healthcare to me in the following manner:

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 Voicemail Messages: ☐ Home Number ☐ Cell Number ☐ Work Number

Access Aspen's Online Patient Portal

I would like to access Aspen's Online Patient Portal so I can view my medical record, appointment information, and update my profile online. ☐ Yes ☐ No

Email address: _____ (required to set up Patient Portal Access)

Patient Statements

I would like to opt out of paper statements, and I consent to receiving them electronically. ☐ Yes ☐ No

By submitting this form, I hereby grant permission to the staff at Aspen Orthopedic Specialists to discuss my health information as listed above.

Signature: _____ Date: _____

Witness: _____

If the patient is a minor or has a legal representative, printed name of legal parent/guardian/representative of the patient and Relationship to Patient: _____