DISCLOSURES TO FAMILY MEMBERS AND FRIENDS

PERSONS
ORTHOPAEDIC SPORTS MEDICINE
& JOINT REPLACEMENT CENTER

Patient Name: _____

Patient DOB: _____ **Patient SSN:** _____

I hereby agree that disclosures may be made to family and friends (listed below as "Included") related to my health or as needed for payment of health care services. I also request that my information not be shared with persons listed below as "Excluded". I also understand that in cases where this form is not accessible or in cases of emergency that the physicians and staff will use their best judgment in complying with my wishes in this matter.

(circle one)	Relationship	Name
Include - Exclude	Spouse	_____
Include - Exclude	Parent(s)	_____
Include - Exclude	Sibling(s)	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____
Include - Exclude	_____	_____

Patient or Guardian Signature: _____ Date: _____