Suncoast
Orthopaedic Surgery & Sports Medicine

The anatomy of leading-edge orthopaedics and sports medical care

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HIPAA/PATIENT CONTACT CONSENT

_____ _____ _____
Patient (Last Name) (First Name) (M.I) Date of Birth (MM/DD/YYYY)

I wish to be contacted in the following manner (please check all that apply):

- □ Home telephone: ( ) _____ - _____
- □ Work telephone: ( ) _____ - _____
- □ Cell phone: ( ) _____ - _____

May we mail a recall appointment reminder to your home? Yes _____ No _____
May we mail test results to your home? Yes _____ No _____

May we leave appointment, billing or medical information on your answering machine/voice mail? Yes _____ No _____

When available, would you like to be able to contact the office through secure electronic messaging via email? Yes _____ No _____

If yes, what is your email address: _____

I give permission to share appointment, billing or medical information with the following persons named below:

_____ _____

_____

_____ _____
Signature of Patient / Parent or Legal Guardian Date