DESIGNATION OF DISCLOSURES

You may disclose my health information as described below:

List **ALL** phone numbers we may try to contact you on:

Phone #:___________________________________ home/cell/work (***circle one***)

Phone #:___________________________________ home/cell/work (***circle one***)

Phone #:___________________________________ home/cell/work (***circle one***)

Okay to leave messages: (*Check all that apply*)

- ☐ On my answering machine
- ☐ With my spouse
- ☐ Leave message with call back number only

I designate the following people listed below as persons involved with my healthcare, or payment relating to my healthcare, for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. **I understand that Arthritis and Osteoporosis Associates will not disclose health information to any person not designated except in the case of an emergency**.

Name:____________________________ **Relation**:_________________ **Phone** #:________________________

Name:____________________________ **Relation**:_________________ **Phone** #:________________________

Name:____________________________ **Relation**:_________________ **Phone** #:________________________

Name:____________________________ **Relation**:_________________ **Phone** #:________________________

Please list **ALL** physicians you see, in addition to your Primary Care Physician, which may request your records in the future.

Name:____________________________ **Phone** #:________________________

Name:____________________________ **Phone** #:________________________

Name:____________________________ **Phone** #:________________________

Name:____________________________ **Phone** #:________________________

Name:____________________________ **Phone** #:________________________

☐ **CHECK HERE TO AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ANY PHYSICIAN THAT MAY REQUEST IT**

Print Name:__________________________

Signature:____________________________ Date:______________________