



Rockland Orthopedics & Sports Medicine, P.C.

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I, _____, HAVE READ THE NOTICE OF PRIVACY FOR ROCKLAND ORTHOPEDICS AND SPORTE MEDICINE.

Signature

Date

Dear Patient:

As you are aware, there are very strict governmental mandated rules concerning patient confidentiality and release of patient's medical information. Therefore, in our continuing efforts to improve patient/physician communication, ROSM can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment.

If you do NOT want us to leave a message on your home or cell number, please sign here:

If there is any FAMILY MEMBER OR FRIEND with whom we may discuss or to whom we may release information and/or prescriptions on your behalf, please list them here: Yes No

Name	Relationship

I understand that I may revoke or change this authorization at any time in writing.

Signature

Date

Print Name

* Diplomate American Board of Orthopaedic Surgery † Diplomate American Board of Physical Medicine & Rehabilitation
‡ Diplomate American Board of Electrodiagnostic Medicine + Diplomate American Board of Independent Medical Examiners

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