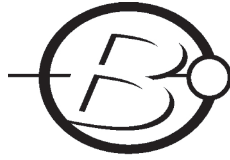

BRIDGER
ORTHOPEDIC
and Sports Medicine

VERBAL COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

PATIENT IDENTIFICATION

Name: ____________________

Date of Birth: ____________________

S.S.#: ____________________

Medical Record #: ____________________

(Signed original will be placed in the medical record.)

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT:	TYPE OF INFORMATION: ALL	Sched./ Appoint.	Medical	Billing/ Insur.
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑
________	________	❑	❑	❑	❑

Specific instructions or Limitations: ____________________

____

____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/
Legal Representative: ____________________ **Date:** __________

Relationship to Patient: ____________________

To revoke this authorization, please send a written request with a copy of this form to the address below:

BRIDGER ORTHOPEDIC AND SPORTS MEDICINE, P.C.

1450 Ellis Street ● Suite 201 ● Bozeman, Montana 59715

(406) 587-0122 ● FAX (406) 587-5548 ● www.bridgerorthopedic.com