

Signature

I have reviewed this privacy practices form and hereby acknowledge that I have read and understand the privacy practices of New West Sports Medicine & Orthopaedic Surgery.

Name of Patient (Print or Type)

X _____
Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

By this form I give permission to New West Sports Medicine & Orthopaedic Surgery to discuss my medical condition with the following people:

Name(s) of Person(s)

Spouse: _____

Parents/Guardian: _____

Children: _____

Other Family Members: _____

Caregivers: _____

Close Personal Friends: _____

Other _____

Name of Patient

Date of Birth

X _____
Signature of Patient

Date

Personal Representative