Andersen ORTHOPEDICS
A Professional Corporation

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I REQUEST THE FOLLOWING RESTRICTIONS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

Patient Name: _____

DOB: _____

Medical information can be discussed with:

- ☐ Patient only
- ☐ Family member or friend:

  Please list name/relationship

  _____
  _____
  _____
  _____

- ☐ Physician _____
- ☐ Other _____
- ☐ No Restrictions
- ☐ Other Restrictions

Signature: _____ Date: _____

Revised 07/03/2013