



3918 Long Beach Boulevard Suite 100 ~ Long Beach, California ~ 90807  
Tel: (562) 424-9000 ~ Fax: (562) 424-9067 or (562) 424-9030

The following list serves as a formal acknowledgement and authorization, on my behalf, to release or discuss any and all information related to my medical condition and treatment with:

- Me, the patient ONLY
- Me, the patient, AND (list person's first/last name and telephone number by the applicable type)...
  - Spouse: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Paternal Parent: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Maternal Parent: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Brother (Sibling): \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Sister (Sibling): \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Son: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Daughter: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Other Family Member: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Other Family Member: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Attorney: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Insurance Company: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Insurance Company: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Other: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Other: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_
  - Other: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**\*\*E-MAIL DISCLAIMER:** Please note that if You (Patient / Guardian) have provided our office with an E-Mail address, you are providing *The Hand & Wrist Center* authorization to communicate medical information, as well as account information, to You (Patient / Guardian), and/or your elected representative(s), through that E-Mail address. Furthermore, this authorization allows our Office to e-mail medical information to any Medical Provider directly involved in your care. If you elect not to have any information communicated via E-Mail, please inform our Staff immediately.

**Note: You may revoke or change any or all parts of this authorization at any time by submitting a written request to the *The Hand & Wrist Center*.** HWC 04-20-09

Patient or Legal Guardian/Representative Name (printed): \_\_\_\_\_  
\*\*\*If Guardian/Representative is completing this form, please state relationship to patient: \_\_\_\_\_

Patient or Legal Guardian/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_