



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: (____) _____ - _____

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

Patient or Legal Guardian Name (printed): _____

***If Legal Guardian is completing this form, please state relationship to patient: _____

Patient or Legal Guardian Signature: _____

Date: _____