DMOS
ORTHOPAEDIC CENTERS
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Communications Form

Patient Name: _____ Date of Birth: _____

Release of Information*

❑ I do not want any other person to have access to my appointments and medical care.

❑ I give permission for the following person(s) to receive and/or discuss information regarding appointments, financial and/or medical care.

***Note**: The release of medical records requires a separate authorization form be completed from this one. This authorization does not provide the below named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Communication Preferences*

***Note**: Medical information will not be left on unidentified answering machines or voicemail messages.

Voicemail: □ Home answering machine □ Cell Phone □ Work voice mail

Phone: □ Home □ Cell □ Work

Appointment Reminder Message: (choose at least one): □Text □ E-mail □ None

I understand I may revoke this communication form at any time by sending written notice to:

Des Moines Orthopaedic Surgeons
6001 Westown Parkway
West Des Moines, IA 50266

Patient/Personal Representative: _____Date:_____

Personal Representative Relationship, if not patient: _____