John M. Conner, M.D.
Board Certified Orthopaedic Surgery

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Dear Patient,

In order to help us stay with the guidelines of **HIPAA,** please list below and person/persons that you authorize us to disclose information to regarding your Protected Health Information. **(You do not need to list any of your doctors.)**

	NAME	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Do we have permission to leave information on your **answering machine** when you are not at home?

Yes_____ **No_____**

_____ _____

Patients Name (Please Print) **Date of Birth**

_____ _____

Patient's (or Guardian's) Signature **Date**