



Registration Form

Patient's Information

Last Name: Anderson First Name: Sarah Middle Initial: M
 Date of Birth: 03/15/1985 Primary Contact Number: Cell Home Work
 Cell Phone: (555) 123-4567 Home Phone: (555) 234-5678 Work Phone: (555) 345-6789
 Email address: sarah.anderson@example.com

Emergency Contact

Full Name: Michael Anderson Relationship: Spouse
 Primary Contact Number: (555) 123-4567 Cell Home Work
 Alternate Contact Number: (555) 234-5678 Cell Home Work

Contact Preferences

I wish to be contacted in the following manner: (check all that apply) Cell Home Work Email	OK To leave a message with Detailed information? Cell Home Work Email (see email request form)	Leave message with call back number only Cell Home Work Email
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Automated Appointment Reminders

Precision Orthopedics has adopted an outside appointment reminder system of which will send you appointment confirmation requests via email 5 days prior, preferred phone two days prior, and a text one day prior to your appointment with limited information for the purpose of notifying you of your appointment time and the provider to which you will be seeing. I authorize my healthcare provider to disclose to this third party service limited Protected Health Information regarding my upcoming appointments. I consent to receiving these messages via email, phone and and/or text (text message rates will apply).

Disclosure of Medical Information

I hereby give permission to Precision Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following individuals (relatives or close personal friends):

Full Name: Emily Rodriguez Relationship: Sister
 Full Name: Robert Thompson Relationship: Father
 Full Name: Jennifer Chen Relationship: Friend

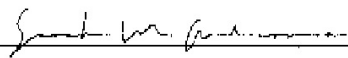
I do not wish to give permission for additional family members, relatives, or close personal friends to have access to any information regarding my medical conditions

Notice of Privacy Practices

SA I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
 (Initials)

Facsimile Authorization for Coordination of Care

I, the undersigned, authorize POSM to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers in the necessary coordination of care for the patient listed below. **Medical records requests require separate form and authorization from this Facsimile Authorization.** I may revoke this authorization by giving POSM five (5) days written notice. This revocation may be by facsimile transmission; however, a **written copy of the revocation must be mailed to POSM as well.**

Signature:  Date: 10/15/2025