

THE

**MONTCLAIR
ORTHOPAEDIC
GROUP**
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**John F. Mendes, M.D.
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RELEASE OF CONFIDENTIAL INFORMATION

I, _____, am aware that Montclair Orthopaedic Group holds my medical information as confidential. My medical care and test results cannot be disclosed or discussed with anyone but myself. I understand this policy and by my signature below I agree to allow Montclair Orthopaedic Group doctors and staff to communicate with the people I have listed below. This permission will stand until changed by myself. I understand that this is my responsibility to forward any changes in writing if I desire to change this release and that verbal changes may not be honored.

Montclair Orthopaedic Group may leave information for me on my answering machine or voice mail.

Home: Yes _____ No _____

Work: Yes _____ No _____

My medical condition and bills may be discussed with:

Name	Phone #	Relationship

I understand this information will stay in my permanent medical record until I give written notice otherwise

Patient Name or Personal Representative (Printed)

Signature

Relationship of Personal Representative

Date