Thomas J. Montgomery, M.D.
A Professional Medical Corporation
Orthopedic Surgery
1301 Camellia Boulevard Suite 102
Lafayette, Louisiana 70508

Dear Patient: This form is made available to you should there be anyone you wish to have listed in your medical record who can receive information from our office concerning your care with Dr. Montgomery and/or Angela Sobiesk, N.P. If you choose not to list anyone, please indicate that choice below and sign the form. Thank you.

Name: _____ Date of Birth: _____

I authorize Thomas J. Montgomery, M.D. and/or staff members under his direction to release any information, including records and reports, of my treatment to:

Name	Relationship to Patient	Daytime Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also release Thomas J. Montgomery, M.D. and/or staff members from all legal liability that may arise from the release of information.

Signed: _____

Print Name: _____

Relationship to patient (only if patient is a minor) _____

Date: _____

I choose not to complete this form at this time. I understand that I may request this form in the future should I elect to have this information available in my medical record.

_____ _____

Date Signature