

PATIENT CONFIDENTIALITY

Patient Confidentiality is a prime concern in this office. Please indicate below with whom our office can or cannot leave a message.

Please check one where appropriate.

	Yes	No	Doesn't Apply
Spouse	_____	_____	_____
Children	_____	_____	_____
Answering Machine	_____	_____	_____
E-Mail (your address if yes) _____	_____	_____	_____
Fax (your fax# if yes) _____	_____	_____	_____

Are you able to receive calls at your workplace? _____

May we call you at your workplace and state who is calling? _____

Due to **HIPAA** confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you - the patient.

Please check with whom we may discuss your situation.

	Yes	No	Doesn't Apply
Spouse	_____	_____	_____
Children	_____	_____	_____

Children & / or Significant Others

Name _____

Relationship _____

Phone _____

Name _____

Relationship _____

Phone _____

Please Sign _____ Date _____