Patient Confidentiality

Patient's Name (please print):___________________________________ Date of Birth:______________

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

Please check where appropriate.

	Yes	No	Does Not Apply
Spouse	______	______	______
Children	______	______	______
Parents	______	______	______
Sibling(s)	______	______	______
Answering Machine	______	______	______
Email Address	______	______	______

If yes, please provide email address: ____

	Yes	No	Does Not Apply
Fax	______	______	______

If yes, please provide fax number:____

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/medical condition unless we have permission from you – the patient.

Please check with whom we may discuss your situation/medical condition.

	Yes	No	Does Not Apply
Spouse	______	______	______
Children	______	______	______

Children and/or Significant Others

Name:____
Relationship:____
Phone:____

Name:____
Relationship:____
Phone:____

Patient's Signature:____Date:___________________