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	____	____	_____
Your cell phone	____	____	_____
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 **HIPPA** confidentiality regulations, should a family member, friend, or relative contact our office, we are <u>not</u> 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	____	____	_____

<u>Children &/ or Significant Others</u>

Name_____
Relationship_____
Phone_____

Name_____
Relationship_____
Phone_____

Please sign_____ **Date**_____