PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern.

Please indicate below with whom our office can or cannot leave a message by checking where appropriate:

CONTACT	YES	NO	DOES NOT APPLY
Spouse/Significant Other			
Parent			
Children			
Home			
Work			
Answering Machine			
Cell Phone			

Are you able to receive phone calls at your workplace? **Y** **N**

May we call you at your workplace and state who is calling? **Y** **N**

Due to 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, or your guardian.

Please check with whom we may discuss your situation:

CONTACT	YES	NO	DOES NOT APPLY
Spouse/Significant Other			
Parent			
Children			

Spouse/Significant Other, Parent, Children approved for contact

Name		Name	
Relationship		Relationship	
Phone		Phone	
Name		Name	
Relationship		Relationship	
Phone		Phone	

______________________________________ ____________

Signature of Patient or Guardian Date