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PATIENT CONFIDENTIALITY FORM

I. Occasionally, it is necessary for our office to call to discuss insurance information, coordinate/discuss referral to another physician, or schedule/cancel appointments.

Please list the family member/other person, if any, whom we may inform, discuss or leave messages with about your appointments. This is only necessary if we cannot reach you:

Name _____ Relationship _____

II. Please print the telephone number where you want to receive calls about your appointment scheduling/cancellations if other than your home phone number:

Work _____ Cell _____

Beeper _____ Other _____

III. Can confidential messages (i.e., messages to call the office regarding appointments) be left on your home answering machine or voicemail?

YES _____ NO _____

IV. Can we call you at your place of employment if you cannot be reached at home?

YES _____ NO _____

V. Would custodial parent need to be notified if non-custodial parent requests copy of medical records.

YES _____ NO _____ NA _____

VI. Acknowledgement of receipt of Notice of Privacy Practices:

YES _____ NO _____

PATIENT NAME (Print) _____

(SIGNATURE) _____ Date _____

Please Circle one – Patient / Guardian / Custodial Parent