IN REGARD TO YOUR CONFIDENTIALITY

Patient Name:_____ DOB:_____

IF THE OFFICE NEEDS TO REACH YOU

May our providers or office staff leave a message for you to contact our office with someone at your home telephone number? ( ) Yes ( ) No

May our providers or office staff leave a message for you to contact our office on your home answering machine? ( ) Yes ( ) No

May our providers or office staff leave a message for you to contact our office with someone at your work phone number? ( ) Yes ( ) No

May our providers or office staff inform any family members or significant others or your test results? ( ) Yes ( ) No

If so, please list the names of those we have your permission to inform

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May our providers or office staff inform any family members or significant others of your referral information? ( ) Yes ( ) No

If so, please list the names of those we have your permission to inform

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CELLULAR TELEPHONES

Please be aware that occasionally our providers are forced to conduct some office business, including patient management, over a cellular telephone. In some instances, there exists a risk that others may overhear these conversations. Our providers try to limit the use of cellular telephones to answering pages which in general are emergencies.

_____ _____

Patient/Guardian Signature Date