Chart #____________

PATIENT CONFIDENTIALITY

In order to maintain patient confidentiality, please indicate below with whom our office can or cannot leave a message.

Please designate one where appropriate.

	YES	If yes, please name		NO
Parent / Spouse / Significant Other	____	______________________		____
Children	____	______________________		____
	____	______________________		____
	____	______________________		____
Relative (if living with you)	____	______________________		____
Relationship		______________________		
	YES	Detailed Message	Call Back Number Only	NO
Home Answering Machine	____	__________	__________	____
Are you able to receive calls at your place of work?	____			____
May we call you at work and state who is calling?	____			____
Work voice mail?	____	__________	__________	____

Should a family member, relative, or friend contact our office, we are not at liberty to discuss your situation unless we have your (the patient's) permission. However, your situation may be discussed if we determine it is an emergency.

Please designate with whom we may discuss your situation.

	YES	If yes, please name	NO
Parent / Spouse / Significant Other	____	______________________	____
Children (please designate one only)	____	______________________	____
Relative (if living with you)	____	______________________	____
Relationship		______________________	

Please Sign: ________________________________ Date: _________