PATIENT CONFIDENTIALITY NOTICE

PATIENT NAME ________________________________ DATE OF BIRTH_________________
Please Print

PLEASE CHECK APPROPRIATE ITEMS

____ List the family members or other persons, if any, whom we MAY inform about your general medical condition and your diagnosis:

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____ List the family members or other persons, if any, whom we MAY inform about your medical condition ONLY IN AN EMERGENCY:

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____ List the family members or other persons, if any, whom ARE authorized to pick up on your behalf, healthcare information such as medical records, prescriptions, tests results, etc:

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Signature of Patient (or Guardian) Date