NAME_____

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Leave appointment messages on/with:			Leave medical information messages on/with:		
Answering machine?	___Yes	___No	**Answering machine?**	___Yes	___No
Office Voice Mail?	___Yes	___No	**Office Voice Mail?**	___Yes	___No
With another person?	___Yes	___No	**With another person?**	___Yes	___No
Send through the mail?	___Yes	___No	**Send through the mail?**	___Yes	___No
Send via email?	___Yes	___No	**Send via email?**	___Yes	___No
Cell Phone?	___Yes	___No	**Cell Phone?**	___Yes	___No

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s) and phone # below:

Name:	**Relationship:**	**Phone:**	**Cell Phone:**

Additional HIPAA Contact Instructions:

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