



PATIENT CONFIDENTIALITY DIRECTIVE

Patient name (Please print)

Date

1. Please list the family members or other persons, *if any*, whom we may inform about your diagnosis. This also includes information about treatment, payment, and health care operations.

2. Please list the family members or significant others, *if any*, who we may inform about your medical condition, but **ONLY DURING AN EMERGENCY SITUATION**:

3. Please print the address of where you would like postcards and/or any other personal correspondence from our office to be sent, *if other than your home address*.

4. Please indicate *if you want* all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

Yes No

5. Please print the telephone number, *if any*, where you want to receive calls about your appointments, lab and x-ray results or other health care information *if other* than your home phone number: (_____) _____ or (_____) _____

** I am fully aware that a cell phone is not a secure and private line.*

6. Can confidential messages, such as appointment confirmation, lab or test results be left on your home answering machine or voicemail?

Yes No

Patient or Guardian signature (if patient is under 18 years)

Date signed

NOTE: You, as the patient, have the right to change this directive at anytime, by filling out and signing a new form.