NAME (PRINT): _____

PRIVACY INFORMATION

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

OK TO LEAVE INFORMATION?

	Appointment Information:	Medical Information:
On home phone (Include Auto Call)?	**___Yes**	**___Yes**
On Cell Phone (Include Auto Call)?	**___Yes**	**___Yes**
On Office Voice Mail?	**___Yes**	**___Yes**
W/ another person?	**___Yes**	**___Yes**
Send via mail?	**___Yes**	**___Yes**
Send via e-mail?	**___Yes**	**___Yes**

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:

Do we have your permission to obtain your medication history from the pharmacy? Yes No

Doctors or Facilities that participate in your healthcare (Name, Address, Phone and Fax #):