TATAR PODIATRY GROUP

PATIENT CONFIDENTIALITY FORM

Patient Name _____ Date of Birth _____

Please check the appropriate box(s).

____ We MAY inform the following family members or other persons about your general medical condition and your diagnosis:

_____

____ List the family members or other persons, if any, who ARE NOT authorized to pick up on your behalf, healthcare information such as medical records, prescriptions, test results, etc.:

_____

____ I do not want messages regarding appointments to be left with someone other than myself, or on a home answering machine or on voicemail.

____ I do not want messages regarding appointments to be left at my place of employment.

____ I do not want messages regarding lab and x-ray results, or other healthcare information to be left with someone other than myself, or on a home answering machine or on voicemail

____ I do not want messages regarding lab and x-ray results, or other healthcare information to be left at my place of employment.

____ I do not want information about me disclosed for treatment or payment or healthcare operations for the following reason (please note that your request may not be granted):

_____

_____

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice as well as the above Patient Confidentiality Form.

_____

(please print) Patient Name Date

_____

Signature Parent or Authorized Representative (if applicable)

_____

Signature (indicates above information verified/updated) Date verified/updated

_____

Signature (indicates above information verified/updated) Date verified/updated