MaxHealth
Family, Internal & Sports Medicine

Patient Name: _____ Date of Birth: _____

Patient Confidentiality and Treatment of Private Medical Information

1. Please list people (and their relation to you) to whom we may release information about your medical condition and/or treatment. Please include anyone who may pick up prescriptions, reports, x-rays, etc. for you. ***Please note: for minors, the parents &/or legal guardians must be listed below, even if completed by a parent or legal guardian.***

Name	**Relationship to Patient**

2. How can we communicate confidential information (e.g., lab results, referrals, diagnostic test results, billing inquiries, appointment reminders)?

Home/Cell Phone (circle one)? Yes No **Is it permissible to leave voice messages or messages with other people who may answer the telephone (circle one)?** Yes No

Work Phone (circle one)? Yes No **Is it permissible to leave voice messages or messages with other people who may answer the telephone (circle one)?** Yes No

E-Mail (circle one)? Yes No **If YES, please provide your current e-mail address (print clearly):**

_____

Notice of Privacy Practices Acknowledgement

By signing below, you acknowledge that you have received the **Notice of Privacy Practices** and you consent to the use and disclosure of your medical information except as expressly stated below. You understand that ***MaxHealth*** has the right to change its **Notice of Privacy Practices** and that you may contact ***MaxHealth*** at any time if you have any questions.

I hereby request the following restrictions on the use and/or disclosure of my information. I understand that you are not required to agree to my requested restrictions and will notify me, in writing, if my request(s) is denied.

Patient (or guardian) Signature: _____ Date: _____

Print Name: _____ Relationship to Patient if a minor: _____