Patient Privacy Questionnaire

Patient's Name ____

1. May we leave confidential messages with anyone who answers the telephone at your home? YES NO
2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voicemail? YES NO
3. Is there a number other than your home number where we can leave a confidential message with anyone answering the telephone regarding appointment, lab results, or other healthcare information? (ex. Cell phone) YES NO
   If yes, please list number(s) (____)________________; (____)____________________
4. If we are unable to reach you by any of the above options, may we leave a confidential message at your place of employment? YES NO
5. Is there anyone you wish we **DO NOT** disclose your medical information to? (i.e. Spouse, Children, Parent(s), etc.)____

If we are unable to reach you by any other means, we will send information through the U.S. Postal service to your home address.

I give Family Health Center, PLLC my consent to use or disclose my Protected Health Information to carry out my treatment, to obtain payment from insurance companies for health care operations.

I have been informed that I may review Family Health Center, PLLC's notice of privacy practices for a more complete description of uses and disclosures before signing the consent.

I understand that Family Health Center, PLLC has the right to change their privacy practices and that I may obtain any revised notices at Family Health Center, PLLC.

I understand that I have the right to request a restriction of how my Protected Health Information is used however; I also understand that Family Health Center, PLLC is not required to agree with the request. If Family Health Center, PLLC agrees to my requested restriction they must follow said restriction.

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

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Signature of Patient (or Guardian if under age 18) Date