

North Dover Ob-Gyn Associates

Patient's Confidentiality Instructions

Patient Name: _____ **Date of Birth:** _____
(Please Print)

It is important for us to honor the confidentiality between patient and physician.

PLEASE CHECK YOUR PREFERENCE BELOW

_____ You may discuss my medical information **ONLY** with me.

OR

_____ I give my permission to discuss my medical information with the following people:

_____ **Relationship** _____

_____ **Relationship** _____

YES or NO (circle one): You may leave medical information (for example: test results) on my voicemail.

Cell #: _____

Email: _____

Home #: _____

I have received a copy of Lifeline Medical Associates, LLC's Notice of Privacy Practices.

Signed: _____ **Date:** _____