



3841 Piper Street Suite T300 Anchorage, AK 99508

PH (907)563-3103 FAX (907) 561-1862

**YOUR RIGHT TO PRIVACY**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**We respect your right to privacy regarding medical information. Without additional written consent, may we share information with your spouse?**

If so, their name \_\_\_\_\_

DOB \_\_\_\_\_

**We understand you may have concerned relatives. Please list the names of adults, children, other family members, and/or contact persons with whom we may share information, without additional written consent:**

\_\_\_\_\_ check or initial for N/A

Name(s) \_\_\_\_\_  
\_\_\_\_\_

**If there are any persons you DO NOT WANT us to give medical information to, please list below.**

\_\_\_\_\_ check or initial for N/A

Name(s) \_\_\_\_\_  
\_\_\_\_\_

**May we leave a message for confirming appointments or results on any of these phone numbers?**

Home phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Yes No

Work phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Yes No

Cell phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Yes No

**If there are any changes to be made on this form, it is the patient's responsibility to inform office of changes.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_