PEORIA WOMEN'S HEALTH

Patient Privacy and Confidentiality statement

In order to ensure patient privacy and confidentiality, our office will not release information to friends or family members without written consent. Please list any family members or other persons, if any, who we may inform about your general medical condition and your diagnosis.

Name Relationship Phone Number

_____

_____

_____

_____

_____

_____

_____

Please print the phone number, if any, where you want to receive calls about your appointments, pap smear results, biopsy results, or other health care information.

_____

Can appointment reminders or messages asking you to call our office be left on your home answering machine or voice mail?

Yes No

Can we contact your at your place of employment to inform you of test results, appointments or other health care information?

Yes No

Please list the address where you would like correspondence from our office to be sent if other than your home address.

_____

Patient Name: _____ Date of Birth _____

_____ _____

Patient/Guardian signature Date

Witness _____ *(office staff only please)*