WELLNESS FIRST | CONCIERGE MEDICINE
THE ART + SCIENCE OF HEALTHY LIVING

FRIENDS AND FAMILY CONFIDENTIALITY FORM

Patient Name: _____

In this office, Patient confidentiality is a prime concern. Please indicate below with whom our office can or cannot leave a message.

Please check where appropriate:

	YES	NO	DOES NOT APPLY
Spouse	☐	☐	☐
Parent	☐	☐	☐
Children	☐	☐	☐
Answering Machine	☐	☐	☐
Home	☐	☐	☐
Work	☐	☐	☐

Are you able to receive calls at your work place? ☐YES ☐NO
May we call you at your workplace and state who is calling? ☐YES ☐NO

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situations:

	YES	NO	DOES NOT APPLY
Spouse	☐	☐	☐
Parent	☐	☐	☐
Child	☐	☐	☐
Friend	☐	☐	☐

Please provide the name, phone number and relationship of the individuals with whom we may discuss your situations (i.e. Spouse, Parent, Child, Friend, Significant Other, etc.):

Name:	Phone#:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____ Date: _____