Daniel C. Coffey, M.D.
Lucas A. Julien, M.D.
Razvan C. Opreanu, M.D.

PATIENT CONFIDENTIALITY CONSENT FORM

Please list the family members or other persons, if any, to whom we may inform about your general medical condition and your diagnosis:

_____

_____

Please list the family members or significant others, if any, to whom we may inform about your medical condition ONLY IN AN EMERGENCY:

_____

_____

Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, as well as other health care information, IF OTHER THAN YOUR HOME PHONE NUMBER: ( ) _____.

Can normal labs and appointments be left on your home answering machine or voice mail?

_____ YES _____ NO

Can appointment reminders be left on your office voice mail at your place of employment?

_____ YES _____ NO

If our office refers you to another specialist, may we release the necessary records to facilitate the referral?

_____ YES _____ NO

PATIENT NAME: _____

_____ _____

Patient/Guardian Signature Date

A photocopy of this release form is to be considered as valid as the original. This release shall remain valid and effective until I specifically revoke it in writing.