PATIENT CONFIDENTIALITY FORM

Patient Name: _____

Patient Date of Birth: _____

Patient confidentiality is a top priority at Georgia Gynecology, P.C. Therefore, it is important that you provide us with the following information to ensure that there is no violation of your privacy.

Georgia Gynecology staff may leave messages regarding results (test/lab), scheduling (appointment, surgery, and procedure) and billing information with the following:

☐ Spouse _____ ☐ Answering machine at home

☐ Voice mail at work ☐ Voice mail at cell phone

☐ Other- Describe: _____

☐ Georgia Gynecology staff **<u>May Not</u>** leave any information.

Please list any family members who may obtain or call and discuss your medical information:

_____

_____

I understand that if the status of any of the above information changes, it will be my responsibility to inform the staff at Georgia Gynecology, P.C.

Patient Signature _____ Date:_____