

Lakewood Family Medicine

Protected Health Information Disclosure Preference- Confidentiality Form

This form details how you wish Lakewood Family Medicine to disclose Protected Health Information (PHI) to you and specific individuals you may name below. This PHI Disclosure Preference form will be kept on file and remains effective until amended or revoked. This disclosure may be amended or revoked at any time. Such amendment or revocation must be in writing, signed and dated. ***Detailed Information:** Includes any type of information regarding your care including (but it is not limited to) scheduled appointments at LFM, referral appointments, lab and test results, and financial information. This may include Mental Health and STD testing.

Patient's Name (Please Print): _____ Date of Birth: _____

Please check/complete ONE box, and then sign and date. Thank you.

I give my permission for LFM to provide **Detailed information* to me, or with any person answering the phone. A **Detailed information* message may be left on my voice mail, or answering machine. I also give my permission for LFM to speak to anyone that may call, or anyone that LFM needs to speak to on my behalf. This may include **Detailed information*.

Signature of Patient/Legal Guardian: _____

Date: _____

LFM is to speak only with me, or to those I have listed below.

When LFM calls, they will not leave any health related information on voice mail, or answering machine. A message may be left indicating that LFM has information for me, and that a return call to LFM is needed. (A direct line, or extension number may be provided for me to call back). Also, a message may be left confirming my LFM appointments, but the nature of the appointment will not be disclosed.

*****PLEASE BE AWARE THAT IF YOU SELECT THIS OPTION, THIS DOES LIMIT WHO LFM MAY SPEAK WITH, AND UNLESS YOU LIST SOMEONE BELOW, LFM MAY SPEAK ONLY WITH YOU.**

I give my permission for LFM to speak with these people listed below regarding ANY of my healthcare information. (These may be a husband, wife, adult children, parents, other family members, or significant others).

Name _____ Relationship _____ Phone _____

Signature of Patient/Legal Guardian: _____

Date: _____