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.

Patient's Name: _____

Birthdate: _____

Please Check One Box Only

☐ **TYPE A – LFM may speak to anyone that calls** on my behalf and may leave detailed messages with anyone who answers the phone. LFM also may leave a brief detailed message on the answering machine.

*_Detailed Information_: Includes any type of information regarding your care including (but it is not limited to) scheduled appointments at LFM, referral appointments, lab results (excluding positive results, medication dosage change, STD screening) and financial information.

☐ **TYPE C - LFM may only speak with me and/or someone I have listed below**. LFM will NOT leave a detailed voicemail, just a message to call back.

Please list family members or friend LFM may speak with on your behalf:

Name _____

Relationship _____

Name _____

Relationship _____

Name _____

Relationship _____

Signature of Patient or Legal Guardian: _____

DATE: _____