LOTUS
Gynecology, Health & Wellness

Restrictions & Release of Personal Healthcare Information

Please list anyone that ***is allowed*** to be present during your exam and/or medical treatment

1. _____

2. _____

3. _____

Please list any person(s) that ***we may discuss*** your medical treatment or condition with.

1. _____

2. _____

3. _____

Please list any person(s) that we are ***not to discuss*** your medical treatment or condition with.

1. _____

2. _____

3. _____

We will need to contact you from time to time regarding appointments and/or your care. The information may be confidential. Please check the method of contact allowed by you.

_____	_____	_____
[ ] Home Telephone	[ ] Cell Phone	[ ] Work Telephone
_____	_____	_____
[ ] Fax Machine	[ ] Leave Message	[ ] Email

I understand all precautions will be taken to protect my privacy. I will notify this office in writing of any changes to this document.

_____	_____	_____
Printed Name	**Patient Signature**	**Date**

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