With my Consent, Skyview Orthopedic Associates may use and disclose my protected health information (PHI).

Signature:____Date:___________________

PRIVACY INFORMATION

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

May we leave appointment messages on/with:			May we leave other medical information on/with:		
Your answering machine?	Yes____	No____	Your answering machine?	Yes____	No____
Office Voice Mail?	Yes____	No____	Office Voice Mail?	Yes____	No____
With another person?	Yes____	No____	With another person?	Yes____	No____
Through the mail?	Yes____	No____	Through the mail?	Yes____	No____
Via email?	Yes____	No____	Via email?	Yes____	No____
Cell Phone?	Yes____	No____	Cell Phone?	Yes____	No____

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list the name(s) and relationship(s) with whom we may discuss this information below:

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