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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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