

**ST. LUKE'S CENTER FOR ADVANCED GYNECOLOGIC CARE**  
**Patient Privacy Form**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

As a patient of our practice, from time to time we may need to communicate with you when you are not in our office. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate medical information to you, and to others involved in your care. Examples of medical information include labs, cultures, biopsies, and appointments etc.

Without specific permission we will not release any of your medical information to any other person. In some cases you may wish for another person to have access to your medical information. Can you please identify those individual(s) and their relationship to you (i.e. significant other, parent, son, daughter, etc.):

Name	Relationship
_____	_____
_____	_____

In the event that no one is available to answer your phone, we need your permission to leave certain types of information on your answering machine, or voice mail. Please indicate your preference by checking one or more of the boxes below.

- Do not leave any medical information on either the answering machine or voice mail.
- I give permission to St. Luke's Center for Advanced Gynecologic Care to leave the following forms of information pertaining to me on my home answering machine or voice mail at the number(s) listed below.

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Appointment Reminders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Test Results	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any type of Medical Communication	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I Assume responsibility to inform the practice of changes in my above information.

Name (Please Print) \_\_\_\_\_

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