PATIENT PRIVACY

AND

PHONE MESSAGES

Patient Name: _____**Date of Birth**_____

(Please Print)

PEDIATRIC PATIENTS ONLY:

Mother (or Legal Designee): _____

(Please Print)

Father (or Legal Designee): _____

(Please Print)

How our office should reach you:

Primary ( )	**Type:** Home Mobile Work	**May we leave a message or voice mail?** **Circle:** Yes or No
Other ( )	**Type:** Home Mobile Work	**May we leave a message or voice mail?** **Circle:** Yes or No
Other ( )	**Type:** Home Mobile Work	**May we leave a message or voice mail?** **Circle:** Yes or No
Other ( )	**Type:** Home Mobile Work	**May we leave a message or voice mail?** **Circle:** Yes or No

SHARE: (List the full name of the family members and/or friends who are or may be involved with your care that Otsego Memorial Hospital may share your health information with)

DO NOT SHARE MY HEALTH INFORMATION WITH THE FOLLOWING: (List the full name)

My signature below indicates I have completed the above sections to the best of my ability. I understand that I may change the responses provided at any time by making a change in writing.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____ _____

Printed Name of Parent or Legal Guardian Date