Progressive Gynecology

PATIENT RECORD OF DISCLOSURE

Dear Patient,

Your right to privacy is very important to us. To help ensure your privacy we would like to know your preferences regarding communications from our office.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ Mail to my home address
- ☐ Mail to my work/office address
- ☐ Fax to this number

_____

☐ Cell Phone/Mobile phone_____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

☐ I give permission to Progressive Gynecology to disclose my protected health information to the designated person(s) listed below:

_____

Print Name(s)

_____ _____

Patient Signature Date

_____ _____

Print Name Birthdate