PONCE PRIMARY CARE

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PATIENT CONFIDENTIALITY FORM

TO ENSURE THAT THERE IS NO VIOLATION OF YOUR PRIVACY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:

I authorize Ponce Primary Care to communicate details of my care that includes test results, lab results, appointment information, and other medical and administrative information by:

☐ Email: _____ ☐ Text: _____ ☐ Phone:_____

☐ Mail: _____

In the event that I, _____, cannot be reached or have a medical emergency, Ponce Primary Care may leave any test result, lab result, appointment information, or other confidential medical information with the following:

Spouse	Name: _____	Number: _____
Children	Name: _____	Number: _____
	Name: _____	Number: _____
Other	Name: _____	Number: _____
	Name: _____	Number: _____

If there is anyone with whom you DO NOT wish us to discuss this information with, please specify below.

_____

_____

_____ _____

PATIENT SIGNATURE DATE