Alliance Medical Group
Waterbury HEALTH

HIPAA PRIVACY RESTRICTION QUESTIONNAIRE

Patient Name _____ Date of Birth _____
Home Phone _____ Cell Phone _____
Work Phone _____

Do you have an Advance Directive or Living Will? ❑ Yes ❑ No
(If yes, Please bring a copy to your next appointment.)

Where may we call you? ❑ Home ❑ Work ❑ Cell

Where can we leave you messages? ❑ Home ❑ Work ❑ Cell

May we speak to your spouse or significant other regarding your treatment? ❑ Yes ❑ No

Name _____ Relationship _____ Phone Number _____

May we speak to another family member regarding your treatment? ❑ Yes ❑ No

Name _____ Relationship _____ Phone Number _____
Name _____ Relationship _____ Phone Number _____
Name _____ Relationship _____ Phone Number _____

_____ _____
Signature of Person Granting Authorization Date

Relationship to Patient: ❑ Self ❑ Parent ❑ Guardian ❑ POA ❑ Other _____

Pediatric Patients Only: ❑ Call Mother Only ❑ Call Father Only ❑ Call Either Parent
❑ Call Other: _____

_____ _____ _____
Patient Print Name Patient Signature Date

_____ _____ _____
Legal Representative Print Name Legal Representative Signature Date

Relationship to Patient: ❑ Parent ❑ Legal Guardian ❑ Power of Attorney ❑ Other _____