Lakeland Regional Health®

CONFIDENTIALITY PREFERENCE

The following individual(s) may receive information from Lakeland Regional Health about my general medical or behavioral health condition and diagnosis (including treatment, payment, and healthcare options).

Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

Name: _____ Telephone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____

☐ At this time, ***I choose not*** to designate any individual to whom Lakeland Regional Health may share information about my general medical or behavioral health condition and diagnosis (including treatment, payment, and healthcare options).

_____ _____

Patient Name (printed) Date of Birth

_____ _____

Signature of Patient or Responsible Party Date/Time

Provider Name: _____