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: ______________________________