BALLINGER CLINIC, PLLC
PATIENT CONFIDENTIALITY QUESTIONNAIRE

PATIENT NAME (Please Print) ____

Should the need arise, I authorize Ballinger Clinic to share with the following people (spouse, family member, friend) information requarding my medical condition (including treatment, payment, and health care operations):

Name: __________________________ Phone: __________________________

Name: __________________________ Phone: __________________________

Name: __________________________ Phone: __________________________

In case of an emergency and if all other persons listed above are not available Ballinger Clinic may contact:

Name: __________________________ Phone: __________________________

Name: __________________________ Phone: __________________________

Signature ________________________________ Date: ____________________