

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____

Date of Birth: ___ / ___ / _____

I request that all communication to me be made via; (please check all that apply)

- Telephone
 - Home
 - Work
 - May we leave a message? ___Y ___N
- Mail
- Email
- Other: _____

Whom may we release medical information regarding you to? (please check all that apply?)

- Spouse
Name: _____
- Family Member
Name: _____
- Guardian/Caregiver
Name: _____
- Doctor
Name: _____

- Legal
Name: _____

- Insurance
- Work Related
Name: _____
- Other:

All medical information will not be released without consent from patient

Patient Signature

Date