Patient Request for Confidential Communication

Please fill out the top part of this form for any person that you would like us to speak to regarding your care. This will allow us to give this person(s) test results, communicate information from your office visit and other Protected Health Information. We **will not** release a copy of your medical record to this person(s) without your specific written request. This request may be revoked at any time, by written or verbal request.

I, _____ hereby request confidential communication of my protected health information to the following individual(s):

Communications with the patient named above can be directed to:

Additional Point of Contact: _____

Contact Address: _____

Contact Phone: _____

Relationship to Patient: _____

Methods of Communication (Please Circle): Phone Mail

Patient Signature: _____

Patient DOB: _____

Date: _____