Legacy Family Medicine, P.C.

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me of my protected health information be sent or made to me at the alternative means or alternative locations as follows:

Alternative Address _____

Alternative Phone Number _____

I authorize the practice of leaving a message on my answering machine/voicemail:

- ○ Yes
- ○ No

I authorize the release of my protected health information over the telephone to the following individuals:

Name of Person: _____ Relationship: _____

Phone Number: Home _____ Work _____

Name of Person: _____ Relationship: _____

Phone Number: Home _____ Work _____

Name of Person: _____ Relationship: _____

Phone Number: Home _____ Work _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY

- ○ Agrees to patient's request for confidential communications
- ○ Does not agrees to patient's request for confidential communications

Comments_____

_____

Signature: _____ Date:_____

Patient Name:

Date of Birth: