Central Primary Care

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, ______________________________, hereby request **Central Primary Care physician(s),** to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following request:

PHONE:
You can contact me by phone at ___________________________________

Leave messages on answering machine_____YES _____ NO

Leave messages with any other person _____ YES _____NO
(THIS INCLUDES LABS, TEST, X-RAY RESULTS)

IF YES, NAME THE PERSON(S) AUTHORIZED TO RECEIVE MESSAGE:

NAME__________________________ RELATIONSHIP ________________

NAME__________________________ RELATIONSHIP ________________

EMAIL ADDRESS: ____

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SIGNATURE DATE

If you are not the patient, please specify your relationship to the patient: ________________