Michael A. Goldman, DPM
Diplomate, American Board of Podiatric Surgery

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Dr. Michael A. Goldman, DPM and/or his staff be handled in the following manner:

- For written communications: Address to: _____
  _____
  _____

For oral communications: Call: _____(telephone number)

May we leave a message?

Yes ☐ No ☐

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

_____
_____
_____

_____
Patient Signature & Date

417 Eighth Street NE **Charlottesville, VA** **434.295.9153**
405C East Third Street **Farmville, VA** **434.392.6669**