REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of patient_____
Date of birth_____

By signing this form, I authorize FootCare, P.A. to use and disclose my Protected Health Information to the following people listed below to:

Share my Protected Health Information with:
(Please initial applicable authorization)

_____Spouse
_____Parent
_____Guardian
_____Children

_____Others (please list their names on the lines below)

_____
_____
_____

Please provide us with the addresses, phone numbers or any other modes of communication in which you authorize communication.

_____
_____
_____
_____

Disclose my protected health information for the following reasons:

_____To leave an appointment reminder with the person who answers or on my answering machine/voice mail _____at home_____at work.
_____To leave a message to call the office regarding a return phone call, prescription calls, supplies/orthotics are ready or matters regarding my account.
Other:_____

I understand that I have the right to revoke this authorization at any time by notifying the HIPPA Privacy Officer for the appropriate office location.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the law or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

FootCare, P.A. will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I have the right to review the Protected Health Information to be used or disclosed or I may refuse to sign this authorization. FootCare, P. A. reserves the right to receive compensation dependent on the circumstances of disclosure.

_____ Date_____

(Signature of Patient or Legal Guardian)

_____

(Printed Name of Patient or Legal Guardian)