

Communication and Restrictions of Private Health Information (PHI)

Patient Name (Print) Date of Birth Social Security #

The above named patient has requested confidential communication and/or restrictions of the use and disclosure of his/her PHI.

The following persons are able to receive and access any of my PHI.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

You are authorized to orally communicate with me by call me at the following phone numbers:

Home: _____ Work: _____ Cell: _____

You may leave a message: Yes No

You may leave a call back number: Yes No

You may leave an appointment reminder: Yes No

You are authorized to communicate with me in writing at the following address:

Home: _____

Work: _____

Other: _____

You may send an appointment to this address: Yes No

Person designated as my medical power of attorney:

Name: _____ Phone: _____

Signature of Patient/Guardian:

Date:
