OAA
Orthopaedic Specialists

Patient Request for Confidential Communications

Patient: Patient No.:
Address:

Soc. Sec.: Phone:

Date of Birth:

Please consider this a request for confidential communication of my protected health information (PHI). I understand that you will do your best to reasonably accommodate it.

Check all that apply to this request:

Please do not phone me at home. Use the following alternative phone number to contact me: _____.

Please do not phone me at work. Use the following alternative number to contact me: _____.

Please send my mail, including my bills, to this alternative address:
_____
_____
_____

Please do not leave messages on my answering machine/voice mail.

Please do not mail appointment cards to me.

Please do not contact me by email.

Other requests (describe in detail)
Please release medical and billing information to:
_____
_____
_____

_____ **(initial) I understand that the physician or provider to whom I am making this request will make reasonable efforts to accommodate this request. I further understand that in some emergency situations, my PHI may be released.**

I acknowledge that I have received the Notice of Privacy Practice for OAA-Orthopaedic Specialists. OAA-Orthopaedic Specialists is authorized to use and disclose health information for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

Note: Please print all information except signature.

Patient:

Signature of Patient (or patient's personal representative): _____

Date representative: _____

Name of personal representative: _____

Relationship to patient (or other authority): _____