McLaren Medical Group

CONFIDENTIAL COMMUNICATIONS

I request that all communications to me of my protected health information be sent or made to me at the alternative means or alternative locations, as follows:

Alternative address: ______________________________

Alternative telephone: ______________________________

I authorize the practice of leaving a message on my answering machine/voice mail: ☐ Yes ☐ No

FOR APPOINTMENT REMINDERS ONLY:

1) Use cell phone: ☐ Yes ____________________ ☐ No
2) Use e-mail: ☐ Yes ______________________________ ☐ No

I authorize the release of my protected health information over the telephone to the following individuals:

Name of person: ______________________ Relationship: ______________________

Phone number: Home ______________________ Work ______________________

Name of person: ______________________ Relationship: ______________________

Phone number: Home ______________________ Work ______________________

Name of person: ______________________ Relationship: ______________________

Phone number: Home ______________________ Work ______________________

Patient Signature: ______________________ Date: _____ / _____ / ______

Witness Signature: ______________________ Date: _____ / _____ / ______

FOR OFFICE USE ONLY:

☐ Agrees to patient's request for confidential communications

☐ Does not agree to patient's request for confidential communications.

Comments: ______________________________

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Signature: ______________________ Date: _____ / _____ / ______

Patient Name:

Date of Birth: