McLaren Internal Medicine
Residency Group Practice
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

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: _____

_____

_____

Signature: _____ Date: _____ / _____ / _____

Patient Name:

Date of Birth: