Applegate Medical Associates, LLP

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Request for Confidential Communication and/or Restriction on Use/Disclosure of Medical Information and Acknowledgement of Receipt of Privacy Practices

Patient Name: _____ **DOB:** _____

Address: _____
Street Address City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email:_____

I authorize Applegate Medical Associates to communicate my confidential health information to:

Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

I authorize Applegate Medical Associates to communicate with me via the following(check all that apply);

- Cell/home phone
- Ok to leave confidential health care information on home/cell voicemail
- Email
- Text
- Work
- Ok to leave confidential health care information on work voicemail

My **PREFERRED** method of contact is; _____

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I request restriction on communication of the following information, to any source, or to a specific source without my written authorization unless the communication is required for emergency care:

_____

****Signature below constitutes my consent to assessment, treatment, and services. I may revoke this consent at any time**.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES		
Your name and signature below indicate that you received a copy of Applegate Medical Associates Notice of Privacy Practices, on the date indicated below. If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at (541) 868-1876.		
Printed name of Patient:	Signature of Patient:	Date Signed:
Signature of Patient's Representative:	Relationship to Patient:	Reason Patient Unable to Sign: