Applegate Medical Associates, LLP

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Request for Confidential Communication and/or Restriction on Use/Disclosure of Medical Information

Patient Name: _____ **DOB:** _____

Address: _____
Street Address City State Zip

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

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

_____

_____

_____

Any information_____ Information only regarding the following: _____
Initials

_____

Applegate Medical Associates normally communicates with patients via mail, phone and fax. We do not leave confidential information on an answering machine. If you desire an alternative method of communication, please list your specific instructions: _____

_____

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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:

_____

_____

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To our patients: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree with your requested restriction. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communication if medical information by alternative locations only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact, and (2) agree to be responsible for and explain how payment can be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that understand and agree to the above information.

Patient Signature _____ Date _____

_____Request of Communication Confidentiality Accepted _____Request of Communication Confidentiality Denied

Reason for Denial _____

_____Request of Restriction Accepted _____Request of Restriction Denied

Reason for Denial _____

This Restriction and Confidentiality Communication Form will be made part of the above named patients medical record