Communication and Restrictions of Private Health Information (PHI)

_____ _____ _____
Patient Name (Please Print) Date of Birth Social Security Number

The above named patient has requested confidential communication and/or restrictions of the use and disclosure of his/her PHI.

The following person(s) are able to receive and access any of my PHI:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

You are authorized to orally communicate with me by calling me at the following numbers:

Home: _____ Work: _____ Cell: _____

You may leave a message: Yes No

You may leave a call back number: Yes No

You may leave an appointment reminder: Yes No

Email Address: _____
(*I am fully aware that email is not a secure means of communication)

You are authorized to communicate with me in writing at the following address:

Home: _____
Work: _____
Other: _____

Person designated as my Medical Power of Attorney:

Name: _____ Phone: _____
I have a Living Will: Yes No
DNR (Do not resuscitate) _____ Full Code: _____

_____ _____
Patient Signature Date: