Request for Confidential Communication

I, ______________________________ hereby request *Family Medical Care, LTD*
(Name of Patient or Guardian)
to keep communications regarding my protected health information confidential. Please take a moment to complete this form to ensure that we can contact you efficiently while maintaining the privacy of your healthcare information.

I authorize Family Medical Care, LTD, to contact me regarding my medical information by means of the listed methods:

Cell Telephone # ________________________________

May we leave messages on your cell phone voicemail? **Yes** **No**

Work Telephone # ________________________________

May we leave messages on your work voicemail? **Yes** **No**

Home Phone # ______________________________________

May we leave messages on your home answering machine? **Yes** **No**

Email Address ____

May we send messages to your email account? **Yes** **No**

Mailing Address ____

May we mail information or documents to this address? **Yes** **No**

The providers may disclose the following health information only to the following list of people:

- All test results **Yes** **No**
- The entire medical record **Yes** **No**
- Most recent visit **Yes** **No**
- Financial Information **Yes** **No**
- Pick up prescriptions on my behalf **Yes** **No**

Spouse: **Yes** **No** **Name** ____

Parent(s): **Yes** **No** **Name** ____

Children: **Yes** **No** **Name** ____

Other: **Yes** **No** **Name** ________________________ **Relationship** ________________

Other Requests for Confidential Communications ____________________________________

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Patient/Guardian Signature _________________________________ **Date** __________________