FOX VALLEY FAMILY PHYSICIANS

Request to Receive Confidential Communications of Protected Health Information
As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please assist our staff by designating how you prefer to be contacted:

____ HOME # ____________________________

____CELL #______________________________

____WORK# ____________________ext:______

APPOINTMENT CONFIRMATIONS:
Our receptionists will be calling your **HOME** with appointment reminders.
____YES ____NO Leave the message on my home answering machine.
____YES ____NO Leave a message with persons at my home.

ALL OTHER HEALTH INFORMATION:
The physicians and nursing staff often need to speak with you regarding medical issues.
If unavailable, please authorize ONE location where we may leave a message:
____HOME ANSWERING MACHINE
____CELL PHONE VOICE MAIL
____WORK VOICE MAIL

For the message left, please authorize the type of information you would like left:
____ALL PERTINENT INFORMATION
____LEAVE ONLY A REQUEST TO CALL BACK, REFERENCING THE OFFICE #

PERSONS AT HOME NUMBER you authorize us to leave a message with: please indicate their names: (i.e. your spouse: Sally or James Smith, your parent(s): John & Jane Smith)

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_____YES ____NO Send sealed confidential information to my home address
_____YES ____NO Send sealed confidential information to another address:
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Patient (if >18 years old) or **Parent Signature** **DATE**