FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

Request for Confidential Verbal Communication

Federal law permits you to request that we place limits on our disclosure or use of your protected health information. **(*If you DO wish the medical group to disclose protected health information to a SPECIFIC family member, relative, or etc.*)** Please complete this form. We are not required to agree to your request; in some cases it may be impossible or impractical for us to implement it. However, we will try to accommodate all reasonable patient requests. We are also required by law to keep records of your requests and if we do agree to it, we are bound by that agreement and required to honor it.

Print Patient Name: _____DOB:_____

Address: _____

Home Number: _____Other Number: _____

I request that you disclose <u>any</u> of my protected health information to the authorized Individuals listed below:

Name: **Relationship:**

1. _____
2. _____
3. _____

Only three (3) parties can be entered

***** Facey Medical requires a signed Authorization by the patient to obtain copies of Medical Records
* If you are a minor this authorization will only be valid until the age of 18.
* Our Notice of Privacy Practices provides more detailed information about how we may use and disclose protected health information about you. A copy is available at any of our Facey Medical Group Locations.

☐ **Primary Medical Record** **Patient Signature:** _____ Date**:** _____
(Patient/Parent/ Legal Representative) **(Proof of Legal Documentation is required if not signed by patient)**

☐ **Mental Health Record** **Patient Signature:** _____ Date**:** _____
(Patient/Parent/ Legal Representative) **(Proof of Legal Documentation is required if not signed by patient)**

For Office Use Only

Facey Medical Group: _____Date: _____
(Official Confirming Signature)

Patient Name	Medical Record#
Patient Date of Birth	Patient Telephone #
Dr. Name	Dr. # Loc:
Appointment Date	
Insurance Coverage	
Insurance Benefits - Co – Pay	