University Orthopedics

Patient Request for Confidential Disclosure of Protected Healthcare Information

Patients Name: _____, _____, _____
Last First M.I.

Social Security #: _____ - _____ - _____

Patients Address: _____
PO Box / Street / Suite

_____, _____, _____
City State Zip

1. Please [ ]DO [ ]DO NOT contact me via my home telephone.
2. Please [ ]DO [ ]DO NOT contact me via my work telephone.
3. Please [ ]DO [ ]DO NOT send all correspondence, including my bills to my home address.
4. Please [ ]DO [ ]DO NOT leave messages my home/residence answering machine.
5. Please [ ]DO [ ]DO NOT mail appointment card reminders to my home address.
6. Please [ ]DO [ ]DO NOT contact me via my provided email address.
7. Who may we contact and discuss needed information with regarding your condition, treatment, appointment scheduling, and general healthcare information?

_____ _____
Name **Relationship to Patient**

Please consider this a request for me to exercise my rights under the federal and state laws to request the restrictions and/or limitations on the communication of my protected healthcare information.

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.
Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

I understand that that the physician to whom I am making this request will make reasonable efforts to accommodate the terms of this request. I understand that I must provide an alternate address to receive bills and statements if my home and/or primary address is not to be used.

_____ _____
Patient's Signature Person authorized to sign for patient

_____ _____
Date Date