Form F107

REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF MY MEDICAL RECORD

Patient Name: ____________________ **Date of Birth:**____________

Address: ________________________ Telephone No:___________

____

I request that I receive communications regarding information contained in my medical record according to the following means:

Circle and complete the appropriate option:

1. I request that when reasonable, information pertaining to my treatment at WHASN be sent by regular mail to the following address:

   ____

   ____

   ____

2. I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following telephone number:

   ____

3. I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following facsimile number:

   ____

4. I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me according to the following method:

   ____

   ____

   ____

I understand that not every request for confidential communications may be accommodated by the practice due to limitations on the practice's capabilities.

____

Signature of Patient or Personal Representative

____

Date

____

Print Name of Patient or Personal Representative

____

Description of Personal Representative's Authority