REQUEST FOR CONFIDENTIAL COMMUNICATIONS
& PATIENT RECORD OF DISCLOSURES

Name of Patient: _____
(please print)
Date of Birth: _____

I request that all communication to me (by telephone, mail or otherwise) by Family Foot Health Center, P.C. and/or its staff be handled in the following manner:

* **For written communications**:
  OK to use home address: Yes ☐ No ☐
  OK to use work/office address: Yes ☐ No ☐
* **For oral communications**:
  Home telephone number: _____
  Cell telephone number _____
  May we leave a detailed message? Yes ☐ No ☐
  Work telephone number: _____
  May we leave a message with call back number: Yes ☐ No ☐

- **Dr. Lesser/Dr. Milad and staff have my authorization to communicate with and or release information to: (i.e. your medical doctors, family members and/or friend/companion etc. (This must be filled out)**
- _____
- _____
- _____
- _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limits the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose, These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI (Protected Health Information) disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO (Treatment Payment Operations) may be permitted without prior consent in an emergency.

I give my permission for Family Foot Health Center, P.C. to release records to other doctors, insurance companies, disability correspondence and labs pertinent to my medical treatment.
Yes ☐ No ☐

_____
Patient signature or legal guardian

_____
Date