



EMRN:
HCL:

Request for Confidential Oral 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: _____

ALLOW SPECIFIC PEOPLE: - If the box at the left is checked, I request that you disclose **any** of my protected health information to the specific people listed here:

Name:	Relationship:	Phone Number #
<i>*Only three (3) parties can be selected*</i>		
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

*** Facey Medical requires a signed Authorization by the patient to obtain copies of Medical Records ***
*** Please note If you are a minor this authorization will be valid until the age of 18.***

Primary Medical Record Patient Signature: _____ Date: _____
(Patient or Legal Representative) (Proof of Legal Documentation is required)

Mental Health Record Patient Signature: _____ Date: _____
(Patient or Legal Representative) (Proof of Legal Documentation is required)

Facey Medical Group: _____ **Date:** _____
(Official Confirming Signature)

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.