

CONFIDENTIAL COMMUNICATIONS PREFERENCE

Please select all that applies to your needs. Date and sign below.

PROTECTED HEALTH INFORMATION

Please see checked boxes below for authorization of release of PHI: (i.e. surgery type, date, location, Diagnostic type, date, location, etc.)

DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN CALL.

Y N Leave results/PHI on answering machine and/or voice mail.

Y N Number(s) authorized to leave messages regarding PHI.

1. (____)_____

2. (____)_____

3. (____)_____

Addresses to mail PHI information to:

Persons authorized to receive PHI

Name (____) Phone Relationship

Name (____) Phone Relationship

Billing statements and correspondence:

Any correspondence related to your health information will be automatically mailed to your home address unless indicated otherwise. Do you agree to this? Yes No

If No, please provide alternative address:

Address City State Zip Code

I _____ acknowledge in signing this document, then I am giving Muir Orthopedic Specialists permission to release PHI (Private Health Information) to specified people and places listed above.

Parent/Guardian Signature

Date