

# REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: \_\_\_\_\_  
(please print)

Date of Birth: \_\_\_\_\_

I request that all communications to me (by telephone, mail, or otherwise) by Dr. Gregory McNamara and/or his staff be handled in the following manner:

• For written communications: Address to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• For oral communications: Call: \_\_\_\_\_  
Or: \_\_\_\_\_

May we leave a message?

**Yes**      **No**

If the address provided above is not your home address or is not a street address, please provide us with the street address for the purposes of ensuring payment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate the full name of anyone who may be authorized to have access to your confidential medical information. Please document clearly what information can be released. You may rescind this consent at any time with proper written notice.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient/Person Authorized to Sign for Patient

\_\_\_\_\_  
Date

## For Practice Use Only:

Practice:       Accepts       Denies

Privacy Officer Signature: \_\_\_\_\_

Date: \_\_\_\_\_