SOUTH COUNTY HEALTH

SOUTH COUNTY MEDICAL GROUP

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ DOB: _____

I request that **ALL COMMUNICATIONS** from:

Name of Practice: _____

Check off Preference(s):

☐ For **WRITTEN** communications:

- ☐ Addressed to: _____
  _____
  _____
- ☐ Secure Email: _____

☐ For **ORAL** communications:

- ☐ The best number to call: _____
- ☐ May we leave a message? ☐ Yes ☐ No

Who may we discuss your medical condition with if necessary *(not including your physician)*?

Name: _____

Relationship to Patient: _____ Telephone: _____

Medical Durable Power of Attorney? ☐ Yes* ☐ No **Please present documentation* Form Provided? ☐ Yes ☐ No

Name: _____

Relationship to Patient: _____ Telephone: _____

Medical Durable Power of Attorney? ☐ Yes* ☐ No **Please present documentation* Form Provided? ☐ Yes ☐ No

Patient Signature: _____ Date: _____