For Internal Use Only

Patient Account # _____

FOX VALLEY FAMILY PHYSICIANS

Request to Receive Confidential Communications of Protected Health Information
As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

APPOINTMENT CONFIRMATIONS:

Please select the best option below to reach you for ***appointment confirmations*:**

____ HOME # _____Ok to leave message ____Yes ___No

____CELL #_____ Ok to leave message ____Yes ___No

____WORK# _____ext:_____ Ok to leave message ____Yes ___No

If our receptionist calls your **HOME** with appointment reminders…
____YES ____NO Leave a message with persons at my home.

ALL OTHER HEALTH INFORMATION:

Please select the best option below for the physicians and nursing staff to speak with you ***regarding medical issues***.

____ HOME # _____Ok to leave message ____Yes ___No

____CELL #_____ Ok to leave message ____Yes ___No

____WORK# _____ext:_____ Ok to leave message ____Yes ___No

For the message left, please authorize the type of information you would like left:
____ALL PERTINENT INFORMATION
____LEAVE ONLY A REQUEST TO CALL BACK, REFERENCING THE OFFICE #

PERSONS AT HOME NUMBER you authorize us to leave a message with: please indicate their names: (i.e. your spouse: Sally or James Smith, your parent(s): John & Jane Smith) _____

_____YES ____NO Send sealed confidential information to **my home address**
_____YES ____NO Send sealed confidential information to **another address**:

_____

(see other side of form for Patient Identifying Information)

Print Patient Name: **Patient** (if >18 years old) or **Parent Signature**:

_____

FOX VALLEY FAMILY PHYSICIANS

Identifying Information:

_____
Patient (if >18years old) or Parent **Name**

_____ _____
Child Name (if applicable) Child Name (if applicable)

_____ _____
Child Name (if applicable) Child Name (if applicable)

_____
Account Number (office use only)

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Patient Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from my physician.

The notice is also available on our website at www.FVFP.org

_____
Patient (if >18years old) or Parent **Signature**

_____
Date