Print Form

Acct # _____ Dr: _____ Date: _____

Chest, Infectious Diseases & Critical Care Associates, P.C.
1601 NW 114th St., Suite 347
Clive, Iowa 50325-7046

Alternative Communications Request Form

HIPAA prevents release of confidential/personal information to anyone other than whom the patient has specified.

Please Print.
Patient Name: _____ Date of Birth:_____

I give my permission for Chest, Infectious Diseases and Critical Care Associates P.C. to discuss my health/financial information with:

_____

_____

_____

_____

I give my permission to be contacted at any of the following phone numbers:

Home	_____	Ok to leave message/results ☐ Yes ☐ No
Work	_____	Ok to leave message/results ☐ Yes ☐ No
Cell	_____	Ok to leave message/results ☐ Yes ☐ No
Other	_____ (Please specify)	Ok to leave message/results ☐ Yes ☐ No

I give my permission to (please mark all that apply):

☐ Leave messages/results with a family member
Please specify family member: _____

Relationship to patient: _____

Phone number if not living with you: _____

This form will be used as the standard form of communication until I revoke this in writing.

Patient/Guardian Signature: _____ Date:_____

Chest, Infectious Diseases and Critical Care Associates P.C will not discuss any medical/financial information with anyone other than the patient, the patient's legal guardian, or persons specified on this form.

Updated: 8/25/2009