Primary Care Associates
of
Appleton, LTD

Confidential Channel Communication Request

Patient Authorized Methods of Communication

Patient Name_____ Patient Date of Birth_____

Address:(City/State)_____

I request the use of the following means of communication of information related to my personal health, treatment or payment for treatment including but not limited to appointments, test results, diagnosis, insurance coverage and payments. This request supercedes any prior request for confidential channel communications I may have made.

Check all that apply:

____Voice Mail/Answering Machine at telephone numbers:_____ _____

____Standard Mail Delivery

_____My ThedaCare

_____Alternative Mail Delivery Location (provide address and city/state/zipcode)
_____
_____

This authorization will remain in effect until:

_____I revoke in writing OR _____Specified Date _____

Patient Signature:_____ Date:_____

OR

Person Authorized by Patient or other legal guardian:

_____ Date:_____

Complete other side if you authorize someone else to receive healthcare information.

Authorization for disclosure of my healthcare to family or others

Patient Name_____ Patient Date of Birth_____

Address:(City/State)_____

I authorize information regarding appointments, transportation, home care, diagnosis, procedures, test results, and billing information in regards to diagnosis, coverage, and payments to be released to the person or persons listed below. If patient is a minor, certain information can only be released to the parent or guardian until the minor's 12th birthday-- age sensitive information such as pregnancy, HIV, and sexually transmitted diseases cannot be disclosed once the minor turns 12 years of age.

Individuals permitted to receive my healthcare information (one or more) Please print

Name:_____ Phone Number:_____

Address (City/State/Zipcode):_____

Relationship to Patient:_____

Name:_____ Phone Number:_____

Address (City/State/Zipcode):_____

Relationship to Patient:_____

This authorization will remain in effect until:

_____I revoke in writing OR _____Specified Date _____

Patient Signature:_____ Date:_____

OR

Person Authorized by Patient or other legal guardian:

_____ Date:_____