Maryland Primary Care Physicians

REQUEST FOR CONFIDENTIAL HANDLING OF HEALTH INFORMATION

Section 1 Patient Information

Name: _____ (LAST) _____ (FIRST) _____ (MI) _____ (MAIDEN OR OTHER NAME)

Date Of Birth: _____ (MM/DD/YYYY) SS#: _____ Medical Record #: _____

Section 2 Individual Involved In Health Care

The following individual is involved in my health care. I give Maryland Primary Care Physicians, LLC permission to communicate with the person listed below as needed for my ongoing health care activities. *[If you wish to name more than person, please attach a separate sheet listing the additional individual(s).]*

Name: _____ (LAST) _____ (FIRST) _____ (MI) _____ (RELATIONSHIP)

Address: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

Primary Phone: _____ Secondary Phone: _____

MPCP, LLC will acknowledge the individual you have named above as being involved in your health care activities until you notify MPCP, LLC in writing of your intention to retract this permission. This notification is not intended as a replacement for an authorization to release protected health information. In the event the amount of information to be conveyed exceeds the minimal amount necessary for involvement in your on going health care activities, you or your personal representative must complete a valid authorization for release of information.

Section 3 Confidential Communications Method

❑ I elect to receive confidential communications in the following manner:

PRIMARY TELEPHONE NUMBER: _____

❑ **DO** ❑ **DO NOT** leave messages on my voice messaging system. ❑ **DO** ❑ **DO NOT** leave messages with any other person.

SECONDARY TELEPHONE NUMBER: _____

❑ **DO** ❑ **DO NOT** leave messages on my voice messaging system. ❑ **DO** ❑ **DO NOT** leave messages with any other person.

FACSIMILE NUMBER: _____

❑ I elect to pick up confidential communications from the provider's office.

❑ I elect to have the following type of information sent to the alternate address listed below: ❑ **BILLING** ❑ **ROUTINE COMMUNICATIONS**

STREET: _____

CITY: _____ *STATE:* _____ *ZIP:* _____

If for any reason a bill remains unpaid for thirty (30) days, then I understand Maryland Primary Care Physicians, LLC/Physicians Management Group, LLC will revert to the original billing arrangements listed in the patient record.

❑ I authorize Maryland Primary Care Physicians, LLC to contact me regarding the following types of health information using the method I have indicated above:

Diagnostic testing results/appointments ..... ❑ **YES** ❑ **NO**
Rx/Medication availability ..... ❑ **YES** ❑ **NO**
Specialist referral information ..... ❑ **YES** ❑ **NO**
Completed form availability ..... ❑ **YES** ❑ **NO**
Other *(Please be as specific as possible, e.g., treatment regarding a specific illness or diagnosis)*: _____

❑ I ***do not*** wish to be contacted regarding my appointments via MPCP's appointment reminder system.

Section 4 Authorized Signature

I request the confidential handling of my health information as indicated above for the period of: _____ (START) **to** _____ (END)

_____ (PRINTED NAME OF PATIENT OR AUTHORIZED REPRESENTATIVE) _____ (RELATIONSHIP)

X _____ (SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE) _____ (DATE)

Your request will remain in effect until you notify Maryland Primary Care Physicians, LLC in writing of your intention to terminate or modify this request for confidential handling of your health information.

Section 5 Termination Of Request

❑ I revoke my previous request for confidential communication of my health information as outlined above.

❑ I revoke my previous authorization naming the individual listed in Section 3 (and on the accompanying attachment, if applicable) to be involved in my health care.

_____ (PRINTED NAME OF PATIENT OR AUTHORIZED REPRESENTATIVE) _____ (RELATIONSHIP)

X _____ (SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE) _____ (DATE)

Section 6 FOR OFFICE USE ONLY

SIGNATURE VERIFIED: ❑ YES ❑ NO

IF NO, THEN TYPE OF PHOTO IDENTIFICATION PRESENTED: _____

DATE REQUEST IMPLEMENTED: _____ BY: _____

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