Princeton Surgical Specialists, P.C.
Improving lives through excellence in surgical care
833 Princeton Ave. S.W. • POB III, Suite 200-F • Birmingham, AL 35211
(205) 776-8600 • Fax (205) 776-8603

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all communications to me (by telephone, mail, fax, or otherwise) by Princeton Surgical Specialists, P.C. and/or its staff be handled in the following manner:

- ***Written Communications:*** (including appointment reminder cards) be mailed to: send to Home address _____ or

  Other address: _____

- ***Oral/Verbal Communications:*** CALL - Home phone ____ Work Phone ____ Other phone # _____

  Do you have an answering machine: ___ Yes __ No If yes, may we leave a voice message at this number? ____ Yes ____No
  If you do not have an answering machine is there a specific person we need to speak to at the number you have authorized ?

  ___ Yes ___ No If yes, please list name: _____

- This is to notify you there may be times we must fax patient information, if applicable, **to the following entities:** ***your employer for Family Medical Leave Act; disability information; your insurance company, and your physician may request information, etc. (If you do not sign this authorization, etc***. If you do not sign this authorization that we can fax information, then we can not send information if requested by the above entities, and it may delay payment to you or on your account.) **If you check yes, we can fax information, this means if information is requested by the following:** ***your employer for Family Medical Leave Act; disability information, your insurance company, your physician, etc. you agree for us to fax it. This does not mean, do you have a fax machine. Do you authorize us to fax information, to the above entities, if requested?*** ____ Yes ____ No

- **If you do not agree on the confidential communications stated above please specify how you want to be communicated with:**

_____

_____

PATIENT CONTACT INFORMATION

Any physician, staff, employer or representative of Princeton Surgical Specialists, P.C. has my permission to discuss my account and medical condition which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons: ***(All patients must fill in the following on who we can release information to; talk to, by telephone, mail, etc. In addition, patients 14 years of age and older must sign this form to allow their informatoin to be disclosed to the contacts listed below).***

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

____ I do not want anyone to have access to my protected health information unless I provide explicit authorization.

Comments: _____

_____

_____ _____

Signature of Patient or Personal Representative (Including patient 14 years of age and older) Date