Confidential Communication Request

Performance Edge Sports DBA Family Physical Therapy
Anthony J Todt, MSPT, CSCS, Owner
7 Park Ave, Colchester, CT 06415
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(860) 531-3222

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other health-care related information, be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided this medical practice will respond to your written request within 14 days after receiving this request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _____ hereby request use of confidential channels for communication of information related to personal health, treatment or payment for treatment.

Name:_____ Date of Birth:_____ Social Security (last 4 digits):_____

How may we contact you?

Home Phone:_____
Please circle one: Do NOT leave message May leave return number only May leave message

Work Phone:_____
Please circle one: Do NOT leave message May leave return number only May leave message

Cell Phone:_____
Please circle one: Do NOT leave message May leave return number only May leave message

Text Messages (when available): Please circle one: Yes No
Please circle one: Do NOT leave message May leave return number only May leave message

Email Address (when available):_____
Please circle one: Do NOT leave message May leave return number only May leave message

Authorized persons with whom we may share patient's personal health information:
*******This consent has NO expiration unless indicated otherwise in the "Note" area*******

Name:_____ Relationship:_____ Note:_____
Name:_____ Relationship:_____ Note:_____
Name:_____ Relationship:_____ Note:_____

I understand that it is my responsibility to notify the office of any changes to the above listed choices.

Patient Signature: _____ Date: _____
If this form was not completed by the patient, please sign below and state relationship to patient.

Signature: _____ Date: _____
Please circle one: Parent Legal guardian Conservator Personal representative

Effective 01/01/2016