REQUEST FOR CONFIDENTIAL COMMUNICATIONS FROM HARRISBURG FOOT AND ANKLE CENTER

Patient's Name:_____ Date of Birth:_____

I request that all communications to me (by telephone, mail or otherwise) from Harrisburg Foot and Ankle Center and/or its staff, be handled in the following manner:

- For written communications: Address to: _____
- For oral communications: Telephone number: _____
- May we leave a message containing courtesy reminders of upcoming appointments, laboratory and pathology reports, account balances and billing information, authorization for durable medical equipment and insurance coverage? Yes ☐ No ☐
- Do you give us permission to disclose copies of specific health and medical information as identified below to another physician for the purpose of your medical treatment: Laboratory reports, diagnostic imaging films and reports, pathology reports, hospital records, emergency and urgent care records and chart dictation and notes? Yes ☐ No ☐

- Do you give us permission to disclose personal information regarding laboratory reports, diagnostic imaging films and reports, pathology reports, hospital records, emergency and urgent care records, doctors instructions, prescription information, chart dictation and notes to someone other than yourself? Yes ☐ No ☐

If yes, please enter the person/persons name to give this information to: _____

Patient's Signature:_____ Date:_____

RESTRICTION REQUEST FORM
For Use and Disclosure of Patient Health Information

In completing this form, you are requesting that the following restrictions be considered as limitations to the use and disclosure of your protected health information. If we grant your request, we are bound by the terms of the agreement. You will be notified in writing of Harrisburg Foot and Ankle Center's decision to accept or deny your restriction request. Until a decision is reached, your request for restriction will not be honored. I understand that I have the right to revoke this authorization at any time, and must do so in writing and present my written revocation to the health care provider.

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS/HIV, behavioral or mental health services, and treatment for alcohol and drug abuse. NOTE: Federal regulations require a description of how much and what kind of information is to be disclosed with regard to treatment for alcohol and drug abuse. If applicable, describe what records may be released: _____

Requested Restrictions (please provide specific details and dates):

Patient's Name:_____ Date:_____

Signature of Patient of Authorized Representative Relationship to Patient