



Primary Care Associates
of
Appleton, LTD

Confidential Channel Communication Request

Patient Authorized Methods of Communication

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|--|
| Patient Name _____ Patient Date of Birth _____ Address:(City/State) _____ |
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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: _____