



Lawrence Diachet, M.D., FACC
 Curtis A. Hamburg, M.D., FACC
 John A. Morytko, M.D., FACC
 Jonathan S. Roberts, M.D., FACC
 Bernard R. Schrager, M.D., FACC
 Paul H. Seigel, M.D., FACC
 Joseph Willmitch, MPAS, P.A. –C
 Denise Bounds, P.A. –C
 Noe Tacoronte, P.A. –C
 Namisha Patel, P.A. – C

CONFIDENTIAL COMMUNICATIONS REQUEST FORM

I, _____, request confidential communication of my health information when my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me. Please list any and all people that we are allowed to release your medical information too.

(For example: wife/name, husband/name, daughter/son-name. Please be as specific as possible.)

Patient Signature: _____

Date: _____

Printed Name and Date of birth: _____

Effective Date: _____

*****FOR OFFICE USE ONLY*****

Practice's Response to Request:

- _____ Agrees to entire request.
- _____ Denies part of requested action: _____
- _____ Requires more complete/specific information to assess your request.
- _____ The practice cannot reasonably accommodate your request.

Signed: _____

Date: _____

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