REQUEST FOR CONFIDENTIAL COMMUNICATIONS FROM OGDEN GASTROENTEROLOGY/CHAD M. GONZALES, M.D., P.C.

Patient's Name: ____ Date of Birth: ____________________

I request that all communications to me (by telephone, mail or otherwise) from Ogden Gastroenterology, physicians, mid-level providers and/or staff be handled in the following manner:

- For **written** communications: Address to: ____
  ____
  ____
- For **oral** communications: Phone number(s): ____
- May we leave messages containing courtesy reminders of upcoming appointments, laboratory and pathology reports, account balances and billing information, authorization for insurance coverage? 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, doctor's instructions, prescription information, chart dictation and notes to ***someone other*** than yourself? YES NO

  If yes, please write the person(s) name and relationship to you who we may give this information to:

  ____

  ____

Patient's or authorized representative's signature: ____

Relationship to Patient: ____ Date: ______________________________

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RESTRICTION REQUEST FORM

For Use and Disclosure of Patient Health Information (PHI)

By completing this portion of the 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 this agreement. You will be notified in writing of Ogden Gastroenterology'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): ____

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Patient's or authorized representative's signature: ____

Relationship to Patient: ____ Date: ____________________________
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