Internal Medicine of Griffin, LLP
231 Graefe Street
Griffin, GA 30224

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Patient Name: _____Date of Birth:_____
Has requested confidential communication of protected health information.

Designated Contact Person(s) for this Patient:

Name: Relationship to patient: Phone Number:

_____

_____

_____

At times, this office will need to contact you concerning appointments, tests results, etc… If you have a voicemail or answering machine, is it permissible to leave your health information on your answering machine or voice mail?
Yes_____ No_____

_____ _____
Patient Signature Date