Valley Vascular Associates

Request for Confidential Oral Communication and Health Information

Federal law permits you to request that we place limits on our disclosure or use on your protection health information. (***If you Do wish the medical group to disclose protected health information to a SPECIFIC family member, relative, or etc***.) Please complete this form. ***We are not required to agree to your request; in some case it may be impossible or impractical for us to implement it.*** However, we try to accommodate all reasonable patient requests. We are also required by law to keep records on your request and if we do agree to it, we are bound by that agreement and required to honor it.

Print Patient Name: _____ DOB: _____

Address: _____

Home Number: _____ Other Number: _____

O **ALLOW SPECIFIC PEOPLE**: - If the box at the left is checked, I requested that you disclose **any** of my protected health information to the specific people listed here:

Name:	**Relationship:**	**Phone Number:**
1._____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Our notice of privacy practices provides more detailed information about how we may use and disclose protected health information about you. A copy is available at Valley Vascular Associates.

Patient Signature: _____ Date: _____

Expires: _____