THE UNIVERSITY OF TOLEDO
MEDICAL CENTER

Confidential Communications Request Form

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created to protect the privacy of your health information. You have the right to request that communications regarding Protected Health Information be provided through specific means.

I authorize The University of Toledo Medical Center, The University of Toledo Physicians and its affiliates, employees and agents, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication, to contact me for any reason by using any telephone number, email and/or mailing address provided.

Primary Phone Number_____ Primary number is: ☐ Home ☐ Cell ☐ Work Office

E-mail Address: _____

If unable to reach me:
☐ Leave a detailed message at the phone numbers provided above
☐ Leave a message asking me to return your call
☐ _____

The best time to reach me is (day)_____at (time)_____

This Release of Information will remain in effect until terminated by me.

I authorize the release of my information including the diagnosis, health records, examination rendered to me and claims information. This information may be released to:

☐ Spouse _____
☐ Child(ren)_____
☐ Other_____
☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

PRINT Your Name:_____

Your Signature:_____Date: _____/_____/_____

PRINT Witness Name:_____

Witness Signature:_____Date: _____/_____/_____

R E Q