J. Kyle Mathews, M.D. P.A.
Plano OB/GYN

HIPPA
Confidential Communications Request Form

Patient Name: ______________________________

I acknowledge that a copy of Dr. Mathew's Notice of Privacy Practices is available to me.

I request confidential communication of my health information.

My protected health information may be used and/or disclosed for the reasons stated below:

To leave an appointment reminder on my answering machine. At home/cell **Y or N**
At work **Y or N**

To complete and mail/fax short-term disability forms to my employer. **Y or N**

To inform my employer of the date I am able to work or able to return to work via mail or fax. **Y or N**

You may disclose my Protected Health Information to:

_____ My spouse (Name:______________________________DOB:___/___/____

_____ My Mother/Father/Guardian (please cross out those not applicable)
(Name: ______________________________DOB:____/____/_____

_____ The following person(s):______________________________DOB:___/____/____

Printed Name:______________________________ Your DOB:_____/______/______

Patient Signature:______________________________ Date: ________________