DANVILLE POLYCLINIC LTD.

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI)

I authorize Danville Polyclinic, Ltd. to communicate with the following person(s) regarding my protected health information (PHI), or my account.

_____	_____	_____
Patient Signature	*Patient Name (Printed)*	*Date*

Please note: *We will not be able to discuss your healthcare with anyone who is not listed on this form. Completion of this form does not authorize the release of medical records to the individual.*

_____
Mailing Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

_____
Mailing Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

_____
Mailing Name

_____
Street Address

_____
City, State, Zip Code

_____
Telephone Number

I, _____, REVOKE communication to the following person(s).

_____

_____ Date: _____