



Request for Confidential Communication

Joseph A. Rutz, Jr., MD, PC
77 Weaver Road, Suite B
Blairsville, GA 30512

Please contact me in the manner(s) below; (check all that apply)

- Home Phone** _____
- Ok to leave message with detailed information
 - Leave message with call back only
 - Ok to leave message with another person _____

- Work Phone** _____
- Ok to leave message with call back name and number only

- Mail**
- Ok to mail to my home address
 - Ok to mail to my work/office address _____
 - Ok to fax to my office number _____

Do you give us your consent to disclose your health information to physicians we refer you to for additional medical care?

- Consent for Referral:**
- Yes, I give my consent
 - No, I do not give my consent
 - Yes, I give my consent, but with the following restrictions: _____

Request for other confidential communications, please specify:

I agree to reimburse Dr. Rutz for costs associated with this request, which will be explained prior to billing me. yes no

By signing this form, I acknowledge that the above information is accurate and that I have received information from the office regarding HIPAA Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

The HIPAA privacy rules provide you with the right to request a restriction of uses and disclosures of your protected health information (PHI). You also have the right to request that confidential communications regarding PHI be made by alternative means, such as sending correspondence to your office instead of your home.