



Family Care Associates of Effingham, S.C.

1106 N. Merchant St., P.O. Box 665
Effingham, Illinois 62401
217-342-7000
www.familycareassociates.com

Authorization for Confidential Communication

I, _____, hereby give Family Care Associates of Effingham, S.C. permission to
(Name of Patient or Authorized Agent)

release _____ Protected Health Information these individual(s):
(Patient's Name) (DOB)

Name DOB Relationship Telephone #

Name DOB Relationship Telephone #

Name DOB Relationship Telephone #

I understand that this request is valid until it is revoked by me. I understand that I may revoke this request at any time by giving written notice of my desire to do so to Family Care Associates of Effingham, S.C. I also understand that I will not be able to revoke this request in cases where the physician has already relied on it to disclose my confidential Protected Health Information. Written revocation of the request must be sent to Family Care Associates of Effingham, S.C. I understand that additional restrictions for Confidential Communication may be requested.

This Request for Confidential Communication Form supersedes all previous Requests for Confidential Communication Forms.

I, _____, give consent for the following person/persons to pick up my prescriptions and/or sample. **This person must be 18 years of age and must present identification at the time of pick up.**

Name DOB Relationship to patient

Name DOB Relationship to patient

Name DOB Relationship to patient

Printed Name **Date of Birth**

Signature **Date**

If you are not the patient, please specify your relationship to the patient: _____

Colleen Bingham, M.D. Michael G. Brummer, M.D. Jeffrey K. Brummer, D.O.
Jeffrey G. Crowell, M.D. Thomas Heischmidt, M.D. Amanda Bierman, M.D.