

Family Care Associates of Effingham, S.C.

1106 N. Merchant St., P.O. Box 665

Effingham, Illinois 62401

217-342-7000

www.familycareassociates.com

Request 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 to the individual(s) below:
(Patient's Name) (DOB)

Name Relationship Telephone #

Name Relationship Telephone #

Name 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.

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 Relationship to patient

Name Relationship to patient

Name Relationship to patient

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.*