MIDWEST
EAR, NOSE & THROAT SPECIALISTS

Acct #___________

Request for Confidential Handling of Health Information

I, ___________________________________ (print name), request confidential handling of correspondence regarding my health information for the period:

FROM: **Midwest Ear, Nose & Throat Specialists**

TO: ____________________________________ Relationship: __________________________

____ Relationship: __________________________

This request applies to health information involving: (Please circle all that apply).

Speak with the Physician **Speak with a Nurse**

Speak with Scheduling/Receptionist **Speak with the Business Office**

Request Medical Records

I have selected to receive confidential communications in the following way:

______ Patient's family member/members listed above will call the providers office.

______ Patient will pick up communications at the provider's office.

______ Patient will receive any information at an alternate mailing address.

____

Patient Signature Date

Please use the following mailing address for all health information communications that fit in the description provided above.
PRINT MAILING ADDRESS:

____

CITY _________________________________ STATE ____________ ZIP CODE ________________

If you have any questions concerning this confidential handling, please contact:

X____ (651) 632-9706 Date: ________
Signature of Medical Secretary & Medical Records Copy Service

____
Printed Name of Medical Secretary & Medical Records Copy Service