

**Family Care Associates of Effingham, S.C.**

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

Effingham, Illinois 62401

217-342-7000

**Request for Confidential Communication**

I, \_\_\_\_\_, hereby give Family Care Associates of

(Name of Patient or Authorized Agent)

Effingham, S.C. permission to release \_\_\_\_\_

(Patient's Name)

(DOB)

Protected Health Information to the individual(s) below:

\_\_\_\_\_  
*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 Request for Confidential Communication Forms.**

\_\_\_\_\_  
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.*