

Family Care Associates of Effingham, S.C. 217-342-7000
1106 North Merchant, P.O. Box 665 Effingham, IL 62401

Request for Confidential Communication

I, _____, hereby give Family Care Associates of Effingham, S. C. permission to release my Protected Health Information to the individual(s) below.

Name

Relationship

Name

Relationship

Name

Relationship

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.

Signed _____ Date _____

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

-Patients File