REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

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Patient Name (Please Print)
Has requested confidential communication of protected health information

To whom communications for the patient named above may be directed. PLEASE WRITE ANYONE BELOW TO WHOM YOU WISH TO ALLOW DISCUSSION WITH US IN REGARD TO MEDICAL ISSUES OR TO BILLING INFORMATION. IF YOU DO NOT INCLUDE ALL PARTIES, THE CALLER WILL BE GIVEN ANY INFORMATION REGARDING YOUR MEDICATIONS, YOUR TREATMENT, YOUR CONDITION, OR YOUR BILLING. (You need not include other physicians)

_____ _____
Name Relationship

_____ _____
Address Phone

_____ _____
Name Relationship

_____ _____
Address Phone

NOTICE OF PROGRAM ACCESSIBILITY

Mississippi Coast OB/GYN, P.A., and all of its programs and activities are accessible to and usable by disabled persons, including persons with impaired hearing and vision. Our providers do not exclude, deny, or otherwise discriminate against any person on the grounds of race, color, or national origin, or on the basis of disability or age. Access features include:

1. Convenient off-street parking designated especially for disabled persons.
2. Restrooms specifically designed to accommodate the use of wheelchairs and other devices of motility
3. Curb cutouts, sidewalks, and ramps between parking areas and building accesses.
4. Full accessibility to all areas which are available to patient use.
5. A range of assistive and communication aids selected by the physician to work with persons of impaired hearing, vision, speech, or skills, without additional charge from us for their assistance

RED FLAG RULES

I had access to, have read and understand the federal law provision for physicians' offices to protect patients from identity theft. If I have questions, I am aware that I may discuss this matter with any member of the clinic staff.

Please inform the receptionist if you require any assistance not evident to you.

SIGNATURE_____

PRINTED NAME_____

DATE_____