PROGRESSIVE PODIATRY
RECIEPT OF NOTICE OF PRIVACY PRACTICES
ALTERNATE COMMUNICATION REQUEST FORM

I acknowledge that I have received a copy of Progressive Podiatry Notice of Privacy Practices.

Patient Name ____ DOB ______/______/______

Signature of patient or responsible person____

Relationship of Representative to Patient ___________________________ Date_________________

Signature of witness____ Date _________________

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By signing this waiver I release Progressive Podiatry and its staff therein, from any liability for release of information pertaining to my medical care.

I wish to be contacted in the following manner by numbers listed in chart (check all that apply):

Home	Alternate	
❐	❑	O.K. to leave message on voicemail
❑	❑	O.K. to leave message with individual
❑	❑	Leave message with call back number only
❑	❑	Do not leave message

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I, ____, Date of Birth ______/______/______
(Print Full Name)
give permission to the following individuals to obtain the indicated information:

________________________ whose relation to me is ________________ Phone (___) ____ - _________
Name Relationship
________________________ whose relation to me is ________________ Phone (___) ____ - _________
Name Relationship
________________________ whose relation to me is ________________ Phone (___) ____ - _________
Name Relationship

________Prescription refills on my behalf
________ Set up/Cancel appointments
________ Test results on my behalf
________ Speak by telephone on my behalf
________ Pick up prescriptions, orders, or other needs with a photo ID

Effective Date __________________Expires __________________Revoked _____________________

It is the responsibility of the patient to notify the physician's office if there is a charge in the information.