

Bux-Mont Oncology Hematology Medical Associates, PC

CONFIDENTIAL COMMUNICATIONS REQUEST

Patient's Name: _____

Date of Birth: _____

I give my permission for the following person/persons to inquire and receive medical updates regarding my protected health information and billing information. (This may be a relative or friend).

Name _____

Phone #: _____

Relationship _____

Name _____

Phone #: _____

Relationship _____

Name _____

Phone #: _____

Relationship _____

Name _____

Phone #: _____

Relationship _____

In addition, please indicate whether we have your permission to leave any type of information regarding your condition or any test results on an answering machine.

Yes _____ No _____

Patient Signature

Date

Relationship to patient (if signed by personal representative of patient)