Arthritis and Rheumatism Associates, P.C.

Patient Request for Confidential Communications

I, _____, understand that as part of my health care Arthritis and Rheumatism Associates, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Arthritis and Rheumatism Associates, P. C. to contact me in the following ways:

_____ Home Phone	Number: _____
_____ Office Phone	Number: _____
_____ Cell Phone	Number: _____
_____ Fax	Number: _____
_____ Email	Email address: _____
_____ Other	Other: _____

I understand that Arthritis and Rheumatism Associates, P.C. will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

MR# (Internal Use): _____

_____
Date

_____
Print Name

_____
Signature of Patient or Authorized Party

_____
Relationship to Patient