JONES OAKLAND VISION GP., P.A. And JAMES V JONES, O.D.

Request for Confidential Communication and/or Restriction on Use/Disclosure of Medical Information

Patient Name:_______________________________ Date of Birth: ____________________
Patient Address: _____________________________ Home #: _______________________
_____________________________ Work #: _______________________
Cell #: _______________________

I authorize Jones Oakland Vision Group., P. A. to communicate my confidential health information to:

Name: ___________________________________ Phone#: ______________________

I authorize you to discuss/disclose ___ any information
<OR>
___ information regarding the following only:

Jones Oakland Vision Gp./James V. Jones, OD normally communicates with patients via mail, phone, fax or by email through a secured portal. We do not leave confidential information on an answering machine. If you desire an alternate method of communication, please list your specific instructions here:

____
____.

If you wish to restrict communication of any part of your medical information, to any source, or to a specified source, without your written authorization (unless required for emergency care), please list that specific medical information here:

____
____.

TO OUR PATIENTS: You have the right to request that we restrict our use and disclosure of your medical records and information. We do not have to agree to your restrictions. If we do agree to the requested restriction, we will abide by the restriction unless a medical emergency requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you (1) specify the alternative location, address or telephone number and/or the alternative means of contact, and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Patient Signature: ____ Date: ___________________

__Request for Communication Confidentiality ACCEPTED __Request for Communication Confidentiality DENIED
__Reason for Denial:____

__Request for Restriction ACCEPTED __Request for Restriction DENIED
__Reason for Denial____

This form will be made a part of the medical record of the above-named patient.

Jones Oakland Vision Group, P.A., 888 Memorial Drive, Oakland, MD 21550
Phone: 301-334-1016 Fax: 301-334-9729