

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

**Name of Patient:** \_\_\_\_\_  
( please print)

**Date of Birth:** \_\_\_\_\_

I authorize Heartland Podiatry, PC to release information to (Please check all that apply):

\_\_\_\_\_ Spouse : \_\_\_\_\_

\_\_\_\_\_ Children: \_\_\_\_\_

\_\_\_\_\_ Others: \_\_\_\_\_

\_\_\_\_\_ No one

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If billing address is different from the patient's home address please provide the information below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date