Acct # _____

Request for Confidential Handling of Health Information

I, _____ (print name), request confidential handling of correspondence regarding my health information for the period:

FROM: **Midwest Ear, Nose & Throat Specialists**

TO: _____Relationship:_____

_____Relationship: _____

This request applies to health information involving: (Please circle all that apply).

Speak with the physician **Speak with a Nurse**

Speak with the scheduling/Receptionist **Speak with the Business Office**

Request Medical Records

I have selected to receive confidential communications in the following way:

____ Patient's family member/members listed above will call the providers office.

____ Patient will pick up communications at the provider's office.

____ Patient will receive any information at an alternate mailing address.

_____

Patient Signature Date

Please use the following mailing address for all health information communications that fit the decription provided above.

PRINT MAILING ADDRESS:

_____

CITY_____ STATE_____ ZIP CODE _____

If you have any questions concerning this confidential handling, please contact our Business Office at:

Phone: 651.702.0750

Revised 2.2024