# Joseph M. Sperduto, M.D.

**Patient request to have Family Members Communicate on behalf of the patients TPO/Health Form**

Patient Name: _____ DOB: _____

Patient Chart No.:_____ Tel.: _____

Please identify who you would like to have access to your Protected Health and speak with Dr. Sperduto.

_____

_____

_____

_____

_____

By signing this form, patient (or authorized representative) understands that we have the right to refuse to provide further treatment to the patient as of the time of the revocation or restriction (except to the extent that we are required by law to treat individuals).

X_____ X_____

**Signature of patient or Legal Representative** **Date**

***For Internal Use Only***

Date received: _____ Request Denied_____ Request Accepted_____

If denied, state reason for denial: _____

If accepted, date file flagged: _____

_____ _____ _____

**Authorized Practice Representative Sign.** **Print Name/Title** **Date**