Daniel Gaitan Personalized Healthcare

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

_____ _____

Patient Name Date of Birth

Has authorized confidential communication of protected health information, both verbal and written, with the following individuals:

Name: _____

Relationship to Patient: _____

Telephone Number: _____

Address: _____

Name: _____

Relationship to Patient: _____

Telephone Number: _____

Address: _____

This authorization may be revoked or terminated by submitting a written revocation to Dr. Daniel Gaitan and Daniel Gaitan Personalized Healthcare, LLC.

_____ _____

Patient Signature Date