

**PROGRESSIVE MEDICAL, INC.  
REQUEST FOR CONFIDENTIAL COMMUNICATION  
OF PROTECTED HEALTH INFORMATION**

**Person requesting confidential communication of protected health information:**

<b>Patient Name:</b>		<b>Social Security No.</b>
<b>Date of Birth:</b>		<b>Date of Injury:</b>
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>

**Communications with the patient named above should be directed to:**

<b>Name:</b>		
<b>Street Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Telephone Number:</b>		

**If the request for confidential communication will prevent the Progressive Medical, Inc. from submitting claims to the patient's health plan or insurer, the request will be accommodated only if the patient identifies another method of paying for services provided by the medical practice. Please describe any payment arrangements :**

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<b>Signature of Patient or Authorized Representative:</b>	<b>Date:</b>
<b>Relationship of Personal Representative to Patient or Statement of Authority: (if applicable)</b>	

**SUBMIT THIS FORM TO ADDRESS BELOW, OR FAX TO 614-212-8008**

Progressive Medical, Inc. Attn: Medical Records  
250 Progressive Way  
Westerville, OH 43082  
Fax: (614) 212-8008