



BABAJIDE OGUNLANA, DPM, PLLC
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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(Please Print)

Date of Birth: _____

I request that all communication to me (by telephone, mail or otherwise) by West Houston Foot & Ankle Center and/or its staff be handled in the following manner:

For **written** or **oral** communications, you may speak or leave a message with the following individuals:

If someone in your family decides to call and if they are not on the list, we can't disclose any information.

May we leave a message? Yes No

Patient Signature

Date

Privacy Office Signature

Date