

Confidential Communication Request



As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. This medical practice will respond to your written request within 14 days after receiving this request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _____ (print name) hereby request the use of confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

Patient's Date of Birth: _____ Social Security Number: _____

Effective date/ or / Dates of Service for confidential communication:

From: _____ Thru: _____ Dates of Service: _____

Until Further Notice

Please select all that apply

Phone:

Home Phone _____

Work Phone _____

Cell Phone _____

Authorized persons (list names and relationship of authorized person with whom we may discuss your protected health information with: Name: _____

Relationship: Spouse Family Member Parent Friend Personal Representative

Other

Describe below other means you may request for confidential communication.

In the event that I do not answer my phone:

Leave a message on my answering machine voice mail with another person(name) _____

DO NOT leave a message on my answering machine voice mail

Patient Signature: _____ Date: _____

If this form was not completed by patient, please sign below and state relationship to patient:

Signature: _____

Relationship to Patient: Check below

Parent

Legal Guardian

Conservator

Patient's Representative