PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name:

Patient Address:

Medical Record #: Date Of Birth: MM / DD / YY

Other Identifier (Social Security Number):

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my protected health information.

Check all that apply to this request:

- ☐ Please do not phone me at home. Use this alternate phone number to contact me:
- ☐ Please do not phone me at work. Use this alternate phone number to contact me:
- ☐ Please send me mail, including my bills, to this alternate address:
- ☐ Please do not leave messages on my answering machine.
- ☐ Please do not mail appointment reminder cards to me.
- ☐ Please do not contact me by e-mail.
- ☐ Other Request: (please describe):

I understand that the physician (or provider) to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements. I further understand that in some emergency situations, my protected health information may be released.

Date:	Patient Signature:

RETAIN IN PATIENT RECORD

FOR SECURITY PURPOSES THIS DOCUMENT HAS A COLORED BACKGROUND TO PREVENT UNAUTHORIZED DUPLICATION.

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