PATIENT REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS

OF PROTECTED HEALTH INFORMATION

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Yes___ No___ Please indicate your request regarding communication from our office.

Yes___ No___ The office may contact me at my home with confidential information.

Yes___ No___ The office may contact me at my work with confidential information.

Yes___ No___ The office may leave messages on my telephone answering machine.

Yes___ No___ The office is authorized to leave a message with persons at my home telephone.

Yes___ No___ Please send confidential information to my home address.

In urgent matters only, to be determined by my physician, you may disclose pertinent information to _____.

Other (please explain):

_____

_____

_____

_____

Name: _____

Signature:_____

Address: _____ City: _____ Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____