



CONFIDENTIAL COMMUNICATION REQUEST FORM

Purpose: This form is used for documenting an individual's request to use alternative channels or addresses to send their information.

SECTION A: Requester's Personal Information

Name: _____

Address: _____

Phone Number: _____ Email: _____

Medical Record: _____

TO THE REQUESTER: Please read this notice and complete the information required.

You are entitled to request that any communications regarding your information be sent through alternative channels or to an alternative address provided by you. We will try to accommodate your request if (a) it is a reasonable request, (b) it is reasonable for us to contact you through the alternative channel or address, and (c) it can be used to procure payment for your medical services. To complete your request, please fill out Section B below.

SECTION B: Confidential Communication Requested

What health information should we convey to you through alternative channels or to the alternative address?

State how to handle any other information related to the services we provide:

I request that you send my information using the following alternative channels. Provide all the information on the alternative channel we should use:

I request that you send my information using the following alternative address. Provide all the information on the alternative address we should use to send your information:

REQUESTER'S SIGNATURE

Signature: _____ Date: _____

If this request is submitted by the requester's personal representative, please provide the following information:

Name of Personal Representative: _____

Relationship to the Requester: _____

YOU ARE ENTITLED TO RECEIVE A COPY OF THIS FORM.