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REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communications concerning your personal health information be made through confidential channels.

Patient Name: _____

I can be reached by the following:

Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Information to be released to alternate contact (please check any that apply):

_____: Any information regarding appointment dates times or Financial information on my account.
_____: Any medical information.
_____: Other (Specify)_____
_____: ***I prefer NO INFORMATION to be given to anyone other than me.***

Information can also be given to this alternate contact:

Name: _____
Relationship: _____ Phone: _____

Emergency Contact:

_____: Please use the above named person as my emergency contact.

OR

Name: _____
Relationship: _____ Phone: _____

I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke or change this request for confidential communication at any time by submitting it in writing to our office.

Patient Signature: _____ Date: _____