Request For Confidential Communication for Protected Health Information

NOTE: Complete <u>One</u> Form Per Patient

PATIENT INFORMATION:

Name _____ **Date of Birth** _____

Street Address _____

Email Address _____ **Phone Number** _____

1. **Describe the reason for requesting confidential communications:**

   _____

   _____

   _____

2. **Describe the protected health information and dates of service that must be communicated confidentially:**
   For Example: Lab Results, office visit.

   _____

   _____

   _____

3. **Describe the alternative location to be used:**
   ☐ *I request that you communicate with me about my PHI at the following alternative location:*

Address:		Telephone:
City:	State:	Zip Code:

4. **Describe the alternative means of communication to be used:**
   ☐ *I request that you communicate with me about my PHI at the following means:*

   _____

   _____

   _____

I understand that I have the right to request confidential communications of my protected health information (PHI). I also understand that the request for confidential communication will apply to all future communications related to the protected health information (PHI) and dates of service listed above. I understand that I can terminate the request for confidential communication at any time, in writing.

Signature of Legal Representative/Patient 18yrs or older _____ **Date** _____

Printed name of Legal Representative/Patient 18yrs or older _____ **Relationship to Patient** _____