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REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____ [patient name], or the parents or legal guardian of the patient, hereby request that I receive communications regarding my protected health information only by using these methods:

☐ US Mail at this address _____.

☐ E-mail using this address _____@ _____.

☐ By telephone or text at this number (_____) _____ - _____.

☐ Other:

_____

_____

If this affects my payment arrangements, payment will be made as follows:

_____

I understand that you will agree to all reasonable requests for alternative communications, but may deny a request if I do not provide a clear method of contact, or if I do not provide information regarding how payment will be made.

_____ _____

_____ _____

Signature of Client (or Parent or Legal Guardian) Date