

## 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 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 Patient (or Parent or Legal Guardian)

\_\_\_\_\_  
Date