REQUEST FOR CONFIDENTIAL COMMUNICATIONS

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I certify that I understand the privacy risks of mail, telephone and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, laboratory results and referral arrangements. I understand that I have the right to rescind this authorization at any time by notifying us in writing.

Name of Patient: ______________________________________ Effective Date: ____________________ DOB: _______

If we need to reach you during business hours regarding test results, how may we reach you? (check all that apply):

☐ **Home Phone:** __________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Work Phone:** _________________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Cell Phone:** ____________________________

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Written Communication:**

- ☐ Mail to home address
- ☐ Mail to alternate address (see below)

Alternate Address: ____

City/Town, State: _____________________________________ Zip Code: ________________________

I give permission to send test results via secure encrypted email: Yes ____ No ____

E-mail address ____

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following:

____________________________________ Relationship ______________________________________

____________________________________ Relationship ______________________________________

Patient Signature ____ Date ________

Parent/Legal Guardian ____ Date _________

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