

**PATIENT REQUEST FOR CONFIDENTIAL
COMMUNICATIONS**

Patient Name: _____

Patient Address: _____

Medical Record #: _____ Date of Birth: _____

Other Identifier (Social Security Number): _____

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my protected health information (HIPAA). Below are my acceptable numbers that may be called and appropriate people with whom a message can be left. This information will be used to confirm appointments, to give test results, and to obtain any other information that may be needed in regards to the healthcare provided to me by Beaches Ear, Nose and Throat, P.A.

Check all that apply to this request

- Please do not phone me at home. Use this alternate phone number: _____
- Please do not phone me at work. Use this alternate phone number: _____
- Please send me mail, including bills, to this alternate address: _____

- Please do not leave messages on my answering machine
- Please do not mail appointment reminder cards to me
- Other requests (who may we leave messages with, i.e. confirm appointments or results):

I understand that the physician (or provider) to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements. I further understand that in some emergency situations, my protected health information may be released.

Date: _____ Patient Signature: _____