REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

Name: ________________________________

Date of Birth:___________________________

You may request to receive confidential communications of protected health information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

Presently, you will receive communications about your protected health information via the telephone number and address you provided us during your registration.

We may not ask you the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

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Signature:____ Date:______________________
(patient or legal representative)

If representative, state relationship:__________________________

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