



CONFIDENTIAL COMMUNICATION REQUEST OF PHI

This form is to be use by patients to request confidential communication of their protected health information (PHI). We are required by law to accommodate reasonable requests by individuals to receive communications of protected health information by alternative means or at alternative locations.

Our practice is not required to gain an explanation from you as to the basis for this request as a condition of providing communication on a confidential basis.

Designated Method of Contacting the Patient

Communications with _____ should be directed to:
(Name of the Patient)

Mailing Name

Street Address

City, State, Zip Code

Telephone Number

Alternative Method of Communication: _____

Payment for Alternative Communication Arrangements (if necessary)

Payment for alternative services provided to the patient will be made as follows (describe payment arrangement): _____

Patient Name (Type/Print)

Date

Signature of the Patient

We hereby accept this request for confidential communication.

Compliance Officer Name (Type/Print)

We hereby deny this request for confidential communication.

Compliance Officer Signature

Date: _____