Confidential Communication Request for Minors

Practice Name/Address:

Phone/Fax:

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other health-care related information, be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. This medical practice will respond to your written request to make changes within 14 days after receiving this request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _______________________________ hereby request use of confidential channels for communication of
(print name)
information related to personal health, treatment or payment for treatment of ______________________________.
(print patient name)

Patient: Date of Birth: __________________ Social Security # (last 4 digits): _________________________________

Preferred Method of Contact

Home Phone Number ____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Work Phone Number ____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Cell Phone Number ____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Email Address (When Available) ____
☐ Do NOT send message ☐ May send return number only ☐ May relay message

☐ Authorized persons with whom we may share patient's personal health information:

Name: ___________________________________ Relationship: ___________________ Note: ________________________

Name: ___________________________________ Relationship: ___________________ Note: ________________________

Name: ___________________________________ Relationship: ___________________ Note: ________________________

Describe below other means you may request for confidential communication:

Note: Staff may discuss payment/costs of care with the guarantor **without** disclosure of the care provided.

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I understand that it is my responsibility to notify the office of any changes to the above listed choices.

Patient Signature: ______________________________ **Date:** ________________________

If this form were not completed by the patient, please sign below and state relationship to patient:
Signature: ____________________________________ **Date:** ________________________

Relationship to Patient: ☐ Parent ☐ Legal guardian ☐ Conservator ☐ Personal representative

****This Consent will expire in one calendar year ****

A division of Physicians for Women's Health

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