

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by _____ [insert name of Practice] and/or its staff be handled in the following manner:

• For written communications: Address to: _____

• For oral communications: Call: _____
(telephone number)
May we leave a message?
Yes No

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment:

Patient Signature

Date

For Practice Use Only

Practice: <input type="checkbox"/> Accepts <input type="checkbox"/> Denies
Privacy Officer Signature: _____
Date: _____