

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST – Professional Orthopedic & Sports Care

As required by Health Information Portability and Accountability Act (HIPAA) of 1996 you have a right to request that communications concerning your personal health 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, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Phone

I want you to contact me by telephone at: _____

____ Do ___ Do not leave messages on my answering machine.

____ Do ___ Do not leave messages with any other person.

Please indicate name, if any, of individual(s) approved to take above messages:

Diagnosis & Treatment

I, ___ Do ___ Do not want to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

Mail

I want you to contact me at the following address: _____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

____ Parent or guardian of minor patient

____ Guardian or conservator of an incompetent patient

____ Beneficiary or personal representative of deceased patient

Name of Patient: _____