

Request For Confidential Communication

Name: _____ SSN: _____ DOB: _____

Primary Physician: _____ Date of Request: _____

I hereby request to receive confidential communications from the practice in the following manner:

Alternative phone number where I wish to be contacted: _____

Alternative address where I would like my protected health information mailed to me:

Street: _____

City: _____ State _____ Zip _____

Other confidential communication request: _____

You may leave limited protected health information on my voicemail or answering machine (lab or test results, information about scheduling or prep for a test or procedure, or information regarding follow up with specialists).

YES _____ NO _____

You may communicate my protected health information with a family member: YES _____ NO _____

If yes, please list family member(s):

Effective Date: _____

I understand that COPC will notify me if COPC is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency.

Signature of the Patient: _____ Signature of Guarantor: _____

(Sign If Patient Is A Minor)

***Note: COPC reserves the right to communicate sensitive health information only directly to the patient.**

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers offer patients a copy of the office Notice of Privacy Practices and make a good faith effort to obtain an acknowledgment of receipt of same. You may refuse to sign this acknowledgment form.

By signing this form, I confirm that I have been offered the office Notice of Privacy Practices for COPC.

Print Name: _____

Sign Name: _____ Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Policy Acknowledgement, but was unable to do so as documented below:

Date: _____	Initials: _____	Reason: _____
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