



Office Use Only: P#: _____

Dr. #: _____

ADULT REQUEST FOR CONFIDENTIAL COMMUNICATION

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

(Please Print)

Patient Name: _____ Middle Initial: _____ DOB: _____

Primary Physician: _____ **(Please Print)**

You may communicate my protected health information with the following:

(Please Print)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

You may leave limited protected health information on a voicemail or answering machine of the names listed above (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist)

Yes _____ No _____

Address where I would like my protected health information mailed to:

Street _____ Apt _____

City _____ State _____ Zip _____

Phone: _____

You may leave messages on voicemail or Answering Machine **Yes** _____ **No** _____

Email Address: _____ (optional)

I understand 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 situation.

I have been offered the office Notice of Privacy Practices for COPC **Yes** _____ **No** _____

Signature of patient/legal guardian: _____ Date: _____

(if over the age of 18/if under the age of 18)

(Please Print)

Name of person signing: _____ Relationship: _____

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Date received: _____ Entered into Mysis: _____ Entered into IC: _____

Initials: _____