Request for Confidential Communications

Patients should use this form to request that the Practice communicate with them in a different way or a different place.

Name:	
DOB:	Telephone #:
Patient Requests	
Please describe the records requested and the approximate dates of the records:	
Check all that apply	
☐	I would like the Practice to communicate with me in the manner described below and/or at the following address: If by email, I understand that unencrypted email is vulnerable to access by third parties.
☐	I specify the following as an alternative method of payment:
If the patient is the requestor:	
Patient Signature:	Date:
If a patient's personal representative is the requestor:	
Name of Representative:	
Relationship to the Patient:	
I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.	
Representative's Signature:	Date: