

Confidential Communication Authorization

The HIPAA Privacy Act gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means.

Patient Name: _____ Med Rec/Acct # _____

Please indicate how you would like the practice to communicate with you (the patient) (check all that apply):

May we call your home?

- | | | |
|--|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Written communication |
| <input type="checkbox"/> O.K. to leave message with detailed info. | | <input type="checkbox"/> O.K. to mail to home address |
| <input type="checkbox"/> Leave message with call back number only | | <input type="checkbox"/> O.K. to fax to this number:
_____ |

May we call your cell phone?

- | | | |
|--|-----------------------------|--------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cell number: _____ |
| <input type="checkbox"/> O.K. to leave message with detailed info. | | |
| <input type="checkbox"/> Leave message with call back number only | | |

With whom may we leave messages about your care?

Name _____ Relationship to you _____ Phone # _____

Name _____ Relationship to you _____ Phone # _____

Is there anyone you do not wish us to communicate with?

What information do you wish us to leave in a message or with someone else?

- | | |
|--|--|
| <input type="checkbox"/> Message with details | <input type="checkbox"/> Message only to return call to office |
| <input type="checkbox"/> All information necessary | <input type="checkbox"/> Other _____ |

Patient Signature

Date

Print Name

Birth date