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: _____ Patient Date of Birth _____

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

Preferred contact number: _____

May we call your home?

- ❑ Yes ❑ No
- ❑ O.K. to leave message with detailed info.
- ❑ Leave message with call back number only
- ❑ Written communication
- ❑ O.K. to mail to home address
- ❑ O.K. to fax to this number: _____

May we call your cell phone?

- ❑ Yes ❑ No Cell number: _____
- ❑ O.K. to leave message with detailed info.
- ❑ Leave message with call back number only

Whom may we contact in case of emergency and/or leave messages about the patient's care?

Name_____ Relationship to you_____ Phone # _____

Name_____ Relationship to you_____ Phone # _____

Is there anyone you do <u>NOT</u> wish us to communicate with?

_____

_____

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

- ❑ Message with details
- ❑ All information necessary
- ❑ Message only to return call to office
- ❑ Other _____

_____ _____

Signature of Patient or Patient Representative Date

_____

Print Name