

Steadman Hawkins Clinic - Denver

Request for Confidential Communications Regarding Medical Information

I, _____, wish to request that the communication about my health and medical care, which contains Protected Health Information (PHI), be communicated to me in the following manner:

(Please check how you would like to receive your Protected Health Information and provide the information we will need to send the information to you at your preferred location)

_____ By telephone at my home number: _____

_____ By telephone at a different number: _____

_____ By FAX at this number provided: _____

_____ By EMAIL at this email address: _____

_____ By mail at an address other than the one on the record

_____ Please do not leave messages regarding my PHI on my answering machine

_____ SHCD may leave an appointment reminder message on my answering machine

_____ SHCD may discuss and/or leave messages about my PHI and/or accounting issues with the following individuals:

Name

Phone Number

Name

Phone Number

Name

Phone Number

If you cannot be reached at the designated alternative location you specify, SHCD may use other means to contact you.

By signing this form, this communication request will remain in force until revoked in writing.

Printed Name

Signature

Month/Day/Year

Patient Account Name

Patient Account Number

Relationship to Patient

SHCD Employee

Signature

Month/Day/Year