Huntington Medical Foundation

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, (PRINT NAME) ______________________________________
hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Telephone
I want you to contact me by telephone at:
(_____) ______________________________________
☐ Do ☐ Do not leave messages on my answering machine.
☐ Do ☐ Do not leave messages with any other person.

Mail
I want you to contact me at the following address:
____
____

Fax
I want you to contact me at the following fax number:
(_____) ______________________________________

Other
____
____
____

☐ Check here if you agree to pay for the costs associated with your request for an alternate communication channel. These costs have been explained to you.

______________________________________ ____/____/____
SIGNATURE OF PATIENT OR REPRESENTATIVE TODAY'S DATE

____
PRINT PATIENT NAME

If not signed by the patient, please indicate relationship:
☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient

For office use only:

Date Granted: ______________________________________

Date Terminated or Modified: ______________________________