

REQUEST FOR CONFIDENTIAL COMMUNICATION

TO OUR PATIENTS: You have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written requests to receive communications of medical information by alternative means or at alternative locations only if you:

- (1) specify the alternative location, address, or telephone number and/or the alternative means of contact; and
- (2) agree to be responsible for, and explain how payment will be handled, for any additional costs associated with the alternative method of communication.

By your signature below, you acknowledge that you understand and agree to the above information.

Medical Information to be Communicated Confidentially: _____

Alternative Location/Address/Telephone Number/E-mail: _____

Patient Name

Signature of Patient

Date