Women's Health Connecticut

Confidential Communication Request

Practice Name/Address:

Phone/Fax:

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other health-care related 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. This medical practice will respond to your written request to make changes within 14 days after receiving a new request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _____ hereby request use of confidential channels for communication of
(print name)
information related to personal health, treatment or payment for treatment of _____.
(print patient name)

Patient: Date of Birth: _____ Social Security # (last 4 digits): _____

Preferred Method of Contact

Home Phone Number _____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Work Phone Number _____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Cell Phone Number _____
☐ Do NOT leave message ☐ May leave return number only ☐ May leave message

Email Address (When Available) _____
☐ Do NOT send message ☐ May send return number only ☐ May relay message

☐ Authorized persons with whom we may share patient's personal health information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

****This Consent Has NO Expiration unless indicated otherwise in the "Note" area****

Note:_____

_____

Describe below other means you may request for confidential communication:

_____

_____

I understand that it is my responsibility to notify the office of any changes to the above listed choices.

Patient Signature: _____ **Date:** _____

If this form were not completed by the patient, please sign below and state relationship to patient:
Signature: _____ **Date:** _____

Relationship to Patient: ☐ Parent ☐ Legal guardian ☐ Conservator ☐ Personal representative

Effective April 14, 2003 with Updates: 4/29/04; 1/6/10; 4/14/11; 10/18/11; 11/1/13; 1/15/14; 8/14/14; 3/2017