HIPAA PRIVACY RIGHTS REQUEST FORM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS
REGARDING MEDICAL INFORMATION

You have the right to request that we communicate with you privately about your medical care by alternative means or alternative locations than the contact information of the person who pays for your health insurance. Please provide us with your private contact information that you would like us to use. [Insert name of medical practice] will then take reasonable steps to accommodate this request.

I request that [insert name of medical practice] communicate with me **confidentially** about my medical care in the following manner (check the box of your preferred contact information):

☐ **Address where you can contact me confidentially:**

Street Address:

City:

State:

Zip Code:

☐ **Email address to contact me confidentially:**

☐ **Phone number to contact me during the day:**

☐ **Phone number to contact me during the evening:**

_____
Patient Printed Name

_____
Patient/Patient Representative Signature

_____
If Patient Representative, Relationship to Patient

_____

Date