REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF MY MEDICAL RECORD

Patient Name: _____ Date of Birth: ____ /____ /_____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____

I request that I receive communications regarding information contained in my medical record according to the following means:
(Check and complete the appropriate option.)

☐ I request that when reasonable, information pertaining to my treatment at WHASN be sent by regular mail to the following address:

Street Address: _____

City: _____ State: _____ Zip: _____

☐ I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following telephone number:

Phone Number: _____

☐ I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me using the following facsimile number:

Phone Number: _____

☐ I request that when reasonable, information pertaining to my treatment at WHASN be communicated to me according to the following method:

_____

_____

_____

I understand that not every request for confidential communications may be accommodated by the practice due to limitations on the practice's capabilities.

_____

Patient Name

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date

_____

Description of Personal Representative's Authority