ATTACHMENT A

REQUEST TO RECEIVE INFORMATION CONFIDENTIALLY

You have the right to receive confidential communications of your personal health information by alternate means or at alternate locations. **Please be aware that you are not required to provide a reason for your request.** *The practice will attempt to accommodate all* ***reasonable*** *requests.*

Patient Name:	**Social Security/MRN:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please be very specific as to where or how you wish the practice to communicate with you:

_____

_____

_____

_____

_____

_____

Patient/Guardian Signature: _____ Date: _____

_____

Internal use only:
Request:

- ❑ Granted
- ❑ Denied

If denied, reason:

_____

_____

Completed By: _____ Date of Completion: _____