

Dental Health Wellness Center

Patient Request For Confidential Communication

Patient Name: _____

Patient Address: _____

Date of Birth: _____

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of my Protected Health Information.

Confidential Communications

Check all that apply to this request:

Please do not phone me at home. Use this alternate phone number to contact me: _____

Please do not phone me at work. Use this alternate phone number to contact me: _____

Please do not leave messages on my answering machine.

Please do not mail appointment reminder cards to me.

Please do not contact me by e-mail.

Other requests: (please describe): _____

Restricted Communications

Please explain below how, specifically, you want your Protected health Information restricted from DISCLOSURE TO OUTSIDE ENTITIES.

A. WHAT information do you want restricted (not disclosed): _____

B. WHO is restricted from accessing this information? _____

Patient Request For Confidential Communication Cont.

Dental Health Wellness Center

I understand that Dental Health and Well ness Center will make reasonable effort to accommodate this request. I understand that Dental Health and Wellness Center is not required to honor this request when information about me is needed for emergency treatment, or in various instances when the information is permitted, by law, to be released. I further understand that the Dental Health and Wellness Center may terminate this restriction, and I will be informed of the termination. I may also choose to terminate this restriction and must do so in writing. I understand that I may provide an alternate address to receive bills and statements.

Patient Signature: _____

Date: _____