



# CONFIDENTIAL COMMUNICATIONS REQUEST FORM

I, \_\_\_\_\_, request confidential communication of my health information when my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me.  
(Please be as specific as possible.)

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\_\_\_\_ My initials here affirm that failure to disclose my health information in the non-conforming manner stated above could endanger me.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name and Date of Birth \_\_\_\_\_

Effective Date \_\_\_\_\_

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## Practice's Response to Request

\_\_\_\_ Agrees to entire request.

\_\_\_\_ Denies part of requested action because: \_\_\_\_\_

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\_\_\_\_ Requires more complete/specific information to assess your request.

\_\_\_\_ The practice cannot reasonably accommodate your request.

Signed \_\_\_\_\_

Date \_\_\_\_\_