REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Name of Patient: _____
(please print)

Date of Birth: _____

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I request that all communications to me (by telephone, mail, electronic mail or otherwise) by Jane J. Lee, M.D. and staff are handled as follows:

- For WRITTEN Communication Address to:

_____

_____

- For ORAL Communication Call: _____
(Home Phone)

  May we leave a message? _____
  ☐ Yes ☐ No (Cell Phone/Work Phone)

- Electronic Mail Communication Address to:_____
(E-mail address)

If the address above is not your home address OR is not a street address, please provide us with a street address for purposes of ensuring payment:

_____

_____

- I wish to place the following restrictions on disclosure of my health information:

_____

Patient (Guardian) Signature: _____Date:_____

Relationship to Patient: _____

Practice: ☐ Accepts ☐ Denies
Privacy Officer Signature: _____Date: _____