Confidential Communications Request and Authorization

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, ____ hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

What telephone number(s) may we use to contact you?

Home: ___________________________ Cell: ________________________

What email address may we use for correspondence?

____

Should we contact you at home or at work? (Please circle one)

Home Work Both

May we discuss pertinent information with anyone else? Yes No

Name: _________________________ Relationship: ___________________

Name: _________________________ Relationship: ___________________

Name: _________________________ Relationship: ___________________

Note: *If you bring family or friends with you to the appointment we will assume you have authorized us to tell them information about your case or treatment unless you advise us to the contrary. We may also decide in our professional judgment such persons may have a need to have information about your care and treatment, such as for driving or post-operative care.*

I hereby acknowledge that I have received a copy of Metro Medical Associates' Notice of Privacy Practices.

Patient Name: ___________________________ **Date:** ____________________
(Please print)

Signature: _________________________________ **Relationship:** ______________
(Patient or Legal Guardian signature)