Breastlink Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) 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 methods of contact must be provided, and as appropriate, information as to how communication will be handled.

I, ______________________________ (print name) Date of Birth: __________________, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or any matters relating to the care I am receiving at Breastlink Medical Group. This request supersedes any prior requests for confidential channel communications I may have made.

Please select all that apply. Where you list more than one (1) communication option, please indicate which you prefer.

Phone

I want you to contact me by telephone at:

( ) ____________________ and/or ( ) ________________________

☐ **DO** ☐**DO NOT** leave messages on my answering machine.

☐ **DO** ☐**DO NOT** leave messages with any other person.

Please indicate name, if any, of the individual(s) approved to take the above messages:

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Diagnosis & Treatment

I ☐ **DO** ☐**DO NOT** want you to discuss my diagnosis, treatment, or any health related matters with my family members or anyone on my behalf.

If you authorize to speak to members of your family or anyone on your behalf regarding your diagnosis, treatments, or any health related matters, please provide the names of those authorized individuals:

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Mail

I want you to contact me at the following mailing address:

Address: ____

City: ________________________ State: __________ Zip: ____________

Signature: ______________________________ Date: ________________

Print Name: ______________________________

If not signed by patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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Office Use Only: ☐ Alteer Alert Screen updated on ________________ (insert date) by: ______________________ (employee Name)