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CHILDREN'S PEDIATRIC CENTER: EAST MAIN

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

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. Children's Pediatric Center 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, _____ (print full name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment of payment for treatment. This request supersedes any prior request for confidential channel communications I may have made. Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

❒ **PHONE**
I want you to contact me by telephone at: (_____) _____
❒ Do ❒ Do Not - leave messages on my answering machine.
❒ Do ❒ Do Not - leave messages with any other person.

❒ **MAIL**
I want you to contact me at the following address:
Street: _____
City: _____ State: _____ Zip _____

❒ **E-MAIL**
I want you to contact me at the following email address: _____@ _____

❒ **FAX**
I want you to contact me at the following fax number: (_____) _____

❒ Check here if you agree to pay for the costs associated with your request for an alternate communication channel. These costs have been explained to you.

Signed: _____ Date: _____
Print Name: _____

If not signed by the patient, please indicate what your relationship is to the patient:
❒ Parent/Guardian of a minor ❒ Guardian or Conservator of an incompetent patient
❒ Beneficiary or Personal Representative of deceased patient
Name of Patient: _____

For Office Use Only
DATE GRANTED: _____
DATE TERMINATED OR MODIFIED: _____