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CHILDREN'S PEDIATRIC CENTER: EAST MAIN

PATIENT REQUEST TO LIMIT AND/OR RESTRICT USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION OR TO REQUEST CONFIDENTIAL COMMUNICATION

Patient Information

Last Name:______________________ First:______________________ MI:______
Address: ____
City:______________________ State:__________ Zip__________
Preferred Phone: (__________) ______________________________

This is to request: (check the appropriate box)

❐ **An alternate or confidential method of communication from the practice**

Note: Children's Pediatric Center will make every effort to comply with reasonable requests, but make request payment arrangements for expenses if the request requires additional costs to Children's Pediatric Center, for example that all correspondence be sent by certified or express mail.

Please provide the contact information below and any other relevant instructions for your confidential correspondence from Children's Pediatric Center:

Address: ____
City:______________________ State:__________ Zip__________
Phone: ______________ Fax:______________ Email: ______________
SPECIAL INSTRUCTIONS: ______________________________________
____

❐ **A restriction on the use or disclosure of my protected health information**

Note: Children's Pediatric Center is not required to comply with this request. Please see our Notice of Privacy Practices for more information.

Please describe the type of information to be restricted or limited. (Examples: Home phone or address, specific type of medical information, your employer, occupation, office phone or address, information about your spouse or children, prescription information, etc.):

____
____

How would you like to restrict use and (or disclosure of) your protected health information?

____
____

Signature of Patient of Legal Guardian:______________________________ Date: __________