Confidential Channel Communication Request
Diablo Vista Dental Care

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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, _____ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or 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 this #/s: _____
☐ Do ☐ Do not leave messages on my Voice Mail/Answering machine
☐ Do ☐ Do not leave messages with any other person

☐ **Mail**
I want you to contact me at the following address: _____

_____

☐ **E-mail**
I want you to contact me at the following e-mail address: _____

☐ **Fax**
I want you to contact me at the following fax number: _____

☐ **Other Individuals authorized by you to receive any Medical Information about you:**

_____ _____

_____ _____

_____ _____

☐ 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:

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

Name of Patient: _____