Patient #_____

Request for Confidential Communications
Allowing Access to Patients Protected Health Information

Patient Information:
(Last name, First name)_____, _____
Date of Birth (Month/Day/Year)_____/_____/_____

My protected health information may be accessible to the following:

1. Name: _____ Phone Number(_____)_____-_____
   Relationship to Patient: _____

2. Name: _____ Phone Number(_____)_____-_____
   Relationship to Patient: _____

3. Name: _____ Phone Number(_____)_____-_____
   Relationship to Patient: _____

_____ _____ _____
Signature (Patient or Personal Representative) Printed Name Date

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FORWARD THIS REQUEST TO THE HIPAA PRIVACY COORDINATOR FOR APPROVAL

FOR INTERNAL USE: Date of Request Received:_____/_____/_____

☐Request Accepted – Date: _____/_____/_____

☐Request Denied – Date: _____/_____/_____ Reason:_____

HIPAA PRIVACY COORDINATOR: _____ Date: _____