PLASTIC SURGICAL
SPECIALISTS, PLLC

Confidential Communication Request

Acknowledgement of Receipt of Notice of Privacy Practice

As required by Health Information Portability and Accountability Act of 1996 you have the 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 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 or treatment. This request supersedes any prior request for confidential communications I have made.

What telephone number(s) may we use to contact you?

Home _____

Mobile _____

Work _____

What email address may we use for correspondence? _____

May we send written correspondence to your home address? YES NO

May we discuss pertinent information with anyone else? YES NO

If yes, please state name and relationship to you:

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

By signing below, I hereby authorize my health information, as more specifically described as a medical record or protected health information, to be used or disclosed at my request to the above named, Plastic Surgical Specialists staff, and my primary or referring physician.

I hereby acknowledge that I have been presented with a copy of Plastic Surgical Specialists' Notice of Privacy Practices and been given the option to retain a copy.

Patient Name: (please print)_____

Signature:_____ **Date:**_____
(If minor or disabled, Legal Guardian signature)