REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient's Name: ________________________________ Birth Date: ___ /_____/___
MM / DD / YR

Address:

Home Telephone Number: E-mail:

I, ____________________, am requesting that Orchidia Medical Group communicate with me in the alternative manner and/or location described below regarding my health information. I understand that Orchidia Med Spa may deny this request if it imposes an unreasonable administrative burden.

Description of the health information that must be communicated confidentially. The following is a description of the specific health information to which this request applies:

Alternative Manner and/or Location. I request that Orchidia Medical Group only communicate with me in the following manner and/or at the location described below:

By signing this form, I am confirming that it accurately reflects my wishes.

____/_____/_____
Signature Date

If signed by personal representative:
Name of personal representative:

Relationship to participant or nature of authority:

____ _____/_____/_____
Signature of Personal Representative Date

Submit Form to: ____________________ – Orchidia Medical Group