

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