VECINO
HEALTH CENTERS™

Confidential Communications Request

I hereby request that my protected healthcare information including clinical information (e.g., test results, patient instructions), billing information, and other clinic communications (e.g., patient surveys) be communicated to me via the alternate address/phone listed below. I understand that this request for Confidential Communications will apply to all future communications related to the date of service listed below unless I request a change in writing.

This request only applies to communications from this clinic. If you wish to request Confidential Communications from your insurance company, you must contact them directly.

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected/out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, the facility will communicate with me via other means and/or at other locations.

This request is for the date of service/treatment of _____.

Alternate address/phone: Only U.S. addresses and phone numbers will be accepted. Signature and date necessary in order for this request to be processed by the clinic.

Patient Name: _____ Date of birth: _____

Street Address: _____

Suite/Apt. Number (if applicable): _____

City: _____ State/Zip Code: _____

Phone Number: _____

Patient/Patient Representative Signature: _____

Printed Name of Patient Representative: _____

Date: _____ Time: _____

Specific Requests: Please comment on specific requests for communication. For example: “Please only send written communications to me at the following address 123 Main Street, Houston, TX, 77076”; or “please call me for any health care communication only at the following phone number: 713-111-1212.”

_____

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

VECINO HEALTH CENTERS INTERNAL USE ONLY

Patient MRN: _____

Date Received: _____

Accepted or Denied: ☐ Accepted ☐ Denied

If denied, state reason for denial: _____

Method used to communicate decision to the patient: _____

Name and Title of Staff Member: _____

Signature: _____

Date: _____

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