



Confidential Communication Request Form

Privacy Officer

7593 Boynton Beach Blvd., Suite 220

Boynton Beach, FL 33437

Compliance Hotline: (561) 207-2120

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have the right to request that Medical Specialists of the Palm Beaches communicate protected health information to you through confidential communications by alternative means or at alternative locations. You are not required to state the basis for this request. Reasonable requests will be accommodated in accordance with applicable law and organizational policy.

I, _____ (print name), hereby request that communications related to my protected health information, treatment, appointment activity, and/or payment matters be directed to me using the confidential communication methods designated below. **This request supersedes any prior request for confidential communications previously submitted by me.**

Please select all that apply:

- ☐ **Phone** Please contact me by telephone at _____
- ☐ **Yes** ☐ **No** voicemail messages may be left at this number.
- ☐ **Yes** ☐ **No** messages may be disclosed to another individual at this number.
- ☐ **Mail** Please direct written correspondence to the following mailing address: _____
- ☐ **Email** Please direct electronic correspondence to the following email address: _____
- ☐ **Fax** Please direct facsimile correspondence to the following fax number: _____

☐ **Other confidential communication requests:** If you are requesting an alternate confidential communication method or delivery location, please specify below:

Name	Relation	Contact Telephone#
_____	_____	_____
Name	Relation	Contact Telephone#
_____	_____	_____
Name	Relation	Contact Telephone#
_____	_____	_____

☐ I acknowledge that reasonable, cost-based charges may apply to the processing of this request, where permitted. Any applicable charge will be communicated to me in advance of billing.

Signature of Patient/Personal Representative: _____ Printed Name: _____ Date: _____

If signed by a personal representative, indicate representative capacity:

- ☐ Parent or legal guardian of a minor patient
- ☐ Court-appointed guardian or conservator for the patient
- ☐ Personal representative of a deceased patient or decedent's estate
- ☐ Other authorized representative capacity (please specify)

Name of Patient: _____

For office use only:

Date Granted:

Date Modified: