

PATIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

\_\_\_\_\_  
 Last Name                                      First                                      MI                                      Date of Birth (Mo/D/Yr)                      Medical Record #

Select the DHS facility for which this request for confidential communication applies:

<input type="checkbox"/> Los Angeles General Medical Center	<input type="checkbox"/> Rancho Los Amigos National Rehabilitation Center
<input type="checkbox"/> Olive View-UCLA Medical Center	<input type="checkbox"/> High Desert Regional Health Center
<input type="checkbox"/> Harbor-UCLA Medical Center	<input type="checkbox"/> Martin Luther King, Jr. Outpatient Center
<input type="checkbox"/> CHC/Health Center: _____	
<input type="checkbox"/> Other: _____	
Facility Name	Street Address
City	State
State	Zip Code

Note this form is not for requesting a change of address.

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, e-mail address, etc.). Please specify how or where you wish to be contacted:

Indicate what method(s) of communication **NOT** to use: *Circle all that apply.*

Mail                                      Phone                                      Fax                                      E-mail

Alternate Address (postal or email):

\_\_\_\_\_  
 Last Name                                      First                                      M                                      E-mail Address

\_\_\_\_\_  
 Street Address                                      (Apt. No.)                                      City                                      State                                      Zip Code

\_\_\_\_\_  
 Alternate Phone or Fax Number (include area code):                                      /

\_\_\_\_\_  
 Signature of patient or representative:                                      Date

\_\_\_\_\_  
 If representative, give relationship:

**APPROVAL**

\_\_\_\_\_  
 Signature of Treatment Provider:

\_\_\_\_\_  
 Print Name:

\_\_\_\_\_  
 Date:

\_\_\_\_\_  
 Processed by:

\_\_\_\_\_  
 Employee Name

\_\_\_\_\_  
 Signature                                      Title

MRUN

NAME

DOB/GENDER