ORTHO
SAN ANTONIO

## REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, request communication of my protected health information by Ortho-SA by alternative means or at alternative locations. I understand this request applies only to communications from Ortho-SA to the patient.

**I wish to be contacted in the following manner: (Check all that apply)**

___ Home Telephone _____

___ OK to leave a message with details

___ Leave message with call-back number only

___ Written Communication

__ OK to mail to my home address

__ OK to mail to my work/office address

___ Work Telephone _____

___ OK to leave a message with details

___ Leave message with call-back number only

____ Cell Telephone _____

___ OK to leave a message with details

___ Leave message with call-back number only

___ Other _____

As a service to our patients, we provide courtesy appointment reminder calls and other important calls that may be placed using an automated or prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

I wish for the following individuals to be allowed information *verbally*:

Name:_____ Phone #: _____ Relationship to patient: _____

Name:_____ Phone #: _____ Relationship to patient: _____

Name:_____ Phone #: _____ Relationship to patient: _____

**NOTE: This request will remain in effect until you notify us of a change**

_____ _____

Patients Name (PRINT) Patient's Guardian/Representative (PRINT)

_____ _____

Signature of Patient Signature of Guardian/Representative

_____ _____

Date Relationship to Patient/Representative Authority

_____ _____

Date of Birth Date

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**The identity of the requestor has been validated either with a picture ID, such as a driver's license or passport, or Comparison of signatures documented in the medical record by:_____**