Four States Foot Clinic

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Confidential Channel Communication Request

As required by the Heath Information Portability and Accountability Act of 1996 you have a right to request that communication concerning your personal health information be made through confidential channels. Four States Foot Clinic will do its best to accommodate all reasonable requests.

I, _____ (print patient name) DOB: _____
hereby request the use of confidential channels for the communication of information related to my treatment, personal health, and/or payment for treatment.
A description of special communication methods to be used is listed below, (PLEASE specify alternate phone numbers, mailing addresses, etc.):

(1)_____	_____	_____	_____
Name of Person	Address	Phone Number	Relationship
(2)_____	_____	_____	_____
Name of Person	Address	Phone Number	Relationship
(3)_____	_____	_____	_____
Name of Person	Address	Phone Number	Relationship

This authorization:

is in effect on _____.

is effective from _____ to _____.

is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician.

_____ _____
Print Guardian Name Date

_____
Patient or Guardian Signature

Staff Member Processing Request: _____

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Date	Initials	Date	Initials