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:

☐ Los Angeles General Medical Center	☐ Rancho Los Amigos National Rehabilitation Center
☐ Olive View-UCLA Medical Center	☐ High Desert Regional Health Center
☐ Harbor-UCLA Medical Center	☐ Martin Luther King, Jr. Outpatient Center
☐ CHC/Health Center: _____	
☐ Other: _____	

Facility Name Street Address City 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

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HS1022 (3-12)