REQUEST FOR CONFIDENTIAL COMMUNICATION

Name of Requestor

I request that you use the following alternate methods of communicating information related to my personal health, treatment or payment for treatment. THIS REQUEST SUPERCEDES ANY PRIOR REQUEST FOR CONFIDENTIAL COMMUNICATION.

Please select all that apply:

☐ **Phone**	Use this number:	( ) -	
	☐ Do	☐ Do Not	Leave messages on my answering machine
	☐ Do	☐ Do Not	Leave messages with any other person
☐ **Mail**	I want you to contact me at the following address:	Street address	
		City State Zip	
☐ **E-mail**	I want you to contact me at this e-mail address:		
☐ **Fax**	I want you to contact me at this fax number:	( ) -	
☐ **Other requests for confidential communications**			

Signature	Date
Print name	Telephone #

If not signed by the patient, please indicate relationship:

Name of Patient:	
☐ Parent or guardian of minor patient	
☐ Guardian or conservator of an incompetent patient	
☐ Beneficiary or personal representative of deceased patient	
☐ Other (specify)	

RESPONSE TO REQUEST

☐ We agree to use the confidential communication method you requested. If you wish to change this—please complete a new Confidential Communication Request.
☐ We are not able to accommodate some or all of your request because:

We have attached a copy of your request, crossing out any request we cannot accommodate.

Response prepared and sent by:	
( ) - Phone #	e-mail address

CITY OF LINCOLN NEBRASKA