Confidential Communication Request Form

Client Information:
Name: _____
Date of Birth: _____

I request that communication regarding my protected health information (PHI) be sent through the following methods/locations (check all that apply):
☐ Email: _____
(By selecting email, I acknowledge and accept the potential risks of unencrypted communication, including unauthorized access.)
☐ Phone Call (Number): _____
☐ Mail (Alternative Address):
_____
_____

Reason for Request (optional): _____

Acknowledgment by Covered Entity:
☐ Request Approved
☐ Request Denied
(Reason:_____
_____)

Client/Legal Representative Signature
Signature: _____
Date: _____

Legal Representative Information (if applicable):
Name: _____
Relationship to Client: _____

Covered Entity Representative
Name: _____
Signature: _____
Date: _____