Confidential Channel Communication Request

Medical Specialists of the Palm Beaches, Inc.
Privacy Officer
5700 Lake Worth Road, Suite 204
Lake Worth, FL 33463
Compliance Hotline: (561) 207-2120

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____ *(print name)* hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply:

☐   **Phone**   I want you to contact me by telephone at _____
        ☐ **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: _____

_____

☐   **Email**   I want you to contact me at the following e-mail address:

_____

☐   **Fax**   I want you to contact me at the following fax number: _____

☐   **Other requests for confidential communications:** You may designate a representative that is permitted to discuss your medical condition with MSPB on your behalf (specify):

Name	Relation	Contact Telephone #
Name	Relation	Contact Telephone #
Name	Relation	Contact Telephone #

☐   Check here if you agree to reimburse this office for costs associated with this request. Any costs associated with this request will be explained to you before you are billed for them.

Signed: _____ Print Name: _____ Date: _____

If not signed by the patient, please indicate relationship:
     ☐ parent or guardian of minor patient
     ☐ guardian or conservator of an incompetent patient
     ☐ beneficiary or personal representative of deceased patient
     ☐ other (specify)

Name of Patient: _____

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For office use only:
     Date Granted: _____   Date Terminated or Modified: _____

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