

# JALH PHYSICIAN CLINICS

## CONFIDENTIAL COMMUNICATION REQUEST

AS REQUIRED BY THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPPA), YOU HAVE THE RIGHT TO REQUEST THAT COMMUNICATIONS CONCERNING YOUR PERSONAL HEALTH INFORMATION BE MADE THROUGH CONFIDENTIAL CHANNELS. I HEREBY REQUEST THE USE OF THE FOLLOWING CONFIDENTIAL CHANNELS FOR THE COMMUNICATION OF INFORMATION RELATED TO MY PERSONAL HEALTH, TREATMENT OR PAYMENT FOR TREATMENT WHICH INCLUDES MY INSURANCE COMPANY.

MAY WE DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH ANYONE ELSE? (YOU MUST FILL IN THE NAMES AND IT SHOULD INCLUDE PHYSICIANS WHOM YOU SEE REGULARLY) WE CANNOT GIVE ANYONE YOUR APPOINTMENT TIME UNLESS THEY ARE LISTED HERE!

1. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
2. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
3. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_
4. \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

THIS REQUEST IS TO INFORM YOU THAT OUR OFFICE WILL CALL THE PHONE NUMBERS LISTED ON YOUR MEDICAL RECORDS TO REMIND YOU OF YOUR APPOINTMENT, SCHEDULE YOUR APPOINTMENTS, AND PROVIDE TEST RESULTS TO YOU. IF YOU HAVE ANY OBJECTION TO OUR STAFF LEAVING MESSAGES ON AN ANSWERING MACHINE, VOICE MAIL, OR WITH SOMEONE AT THESE NUMBERS, PLEASE NOTIFY THE FRONT RECEPTIONIST AT YOUR APPOINTMENT TODAY. WE WILL ONLY PROVIDE HEALTH INFORMATION TO THE NAMES ABOVE IF IT IS SOMEONE OTHER THAN THE PATIENT ON THE PHONE. WE MAY ALSO SEND CORESPONDECE VIAL MAIL TO YOUR MAILING ADDRESS YOU PROVIDED. OUR OFFICE ALSO PARTICIPATES IN E-PRESCRIBING. YOUR PRESCRIPTION WILL BE SENT DIRECTLY TO YOUR PHARMACY. IF YOU CHOOSE NOT TO PARTICIPATE OR WANT MORE INFORMATION, PLEASE NOTIFY OUR OFFICE.

## PATIENTS RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS AND RESPONSIBILITIES ARE POSTED IN OUR OFFICE WAITING ROOM FOR YOUR REVIEW. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE OFFICE MANAGER.

PATIENT NAME (PRINT) \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_