## Patient Request for Confidential Communications

Patient Name: ___________________________________ Date of Birth: ____________________

Address: ________________________________________City/State/Zip Code: _______________

Telephone # most easily reached: ______________________________________

This is a: ☐ New Request ☐ Change to Prior Request ☐ Withdrawal of Prior Request

I request that All Med Medical Group Physicians accommodate the following request for confidential communications (check preferred delivery method and address or phone number):

Information for which confidential treatment is requested:

_________________________________________ ☐ Delivery Address:

__________________________________________________________________________

☐ Telephone: ________________________________________________

☐ Other (Specify):

___________________________________________________________________________

________________________________________________________________________________

______

By signing this authorization form to request confidential communications from All Med Medical Physicians about my medical information, I understand that:

- I may request to receive communications about my protected health information by alternative means or at an alternative location.
- If my request is granted, this request will apply only to the information I have designated above and communication type (address, telephone, other).
- All Med Medical Physicians will accommodate all reasonable requests and if the request is accepted, All Med Medical Physicians will communicate with me in the manner consistent with this request.

- If All Med Medical Physicians cannot accommodate my request, I will be notified of the denial and the reasons why.
- I have the right to revoke or modify this request at any time. The request must be made in writing and presented to the applicable All Med Medical Physician medical office or mailed to the Director of Health Information. Management at the following address: 4377 Bronx Blvd, Bronx, NY 10466
- Unless otherwise revoked or modified, this restriction will expire on the following date/event/condition: _________________________________. If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed.

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- Under emergency situations, All Med Medical Physicians will first attempt to communicate with me as requested above. If unable to contact me, All Med Medical Physicians will attempt to reach me by other means.
- I understand that signing this request is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this request. Completed forms may be: Dropped off at an All Med Medical Physicians medical office site with Attention to: Practice Administrator

  _________________________________ Signature Patient or Authorized Representative Date

  _________________________________ Print Name of Patient or Authorized Representative

  _____________________________ Relationship to Patient or Authority of Authorized Representative

**For All Med Use Only**
**Date Received: (MO/DY/YR) ___/____/_____**

*Received by (print):* ___________________________________________ *Scanned to HIM by Medical Office*

**Disposition of Request: ____GRANTED ___ DENIED (Notify Requestor)**
**Reason for Denial:**
**__________________________________________________________________________ If request denied, Requestor notified (MO/DY/YR) ___/____/____**