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Laguna Hills, CA 92653

Patient Request to Restrict Manner and Method of Confidential Communication

Date:_____

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

I hereby request to receive confidential communications from my therapist regarding my Protected Health Information, treatment, services and/or payment in the following alternative manner and method (check all that apply):

☐ At a telephone number other than my home number.
That phone number is:
_____

☐ At a mailing address other than my home mailing address.
That mailing address is:
_____

_____

_____

☐ Via email. My email address is: _____

☐ Other. Please specify:
_____

_____

I understand that my therapist has to agree to this request to provide me with the confidential communications regarding my Protected Health Information, treatment, services and/or payment via the above identified alternative manner and method, and that my therapist may condition availability and charges depending on resources available to my therapist.

Signature of Patient or legal representative: _____