Texas Tech University Health Sciences Center **Confidential Communication Request Form**	Patient Name:_____ MRN:_____ DOB:_____

Patient Contact information:

Street Address _____

City, State, ZIP _____

Phone number _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care.

TTUHSC will accommodate reasonable requests. TTUHSC may condition the reasonable accommodation regarding information as to how payment, if any, will be handled and specification of an alternative address or other method of contact. TTUHSC does not require an explanation as to the basis for the request as a condition of providing confidential communications.

Although TTUHSC cannot leave specific test results on answering machines due to our concern for your privacy, we are willing to communicate with you as you specify: (or direct)

❑ Permission to give protected health information or leave messages with the following person or persons:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

❑ Permission to call the following numbers to leave messages (without disclosing protected health information) :

Location: _____ Phone #: _____

Location: _____ Phone #: _____

Location: _____ Phone #: _____

❑ Please note any additional special accommodations needed:

_____

_____

_____

_____	_____	_____
Date	Time	Patient/Other legally authorized person
_____	_____	_____
Witness	Print Name	Print name and relationship to patient