CONFIDENTIAL COMMUNICATION REQUEST FORM

You have the right to request we communicate with you about your medical and/or billing matters by an alternative delivery method, such as by mail or phone, or at an alternative location; i.e. phone number or address.

We will comply with any request that we determine we can reasonably accommodate. Your request as reflected below will be in effect until you change or rescind it by submitting a new request form.

Please complete this form in its entirety to accurately reflect your communication requirement(s) and submit to: Health Services, LLC; *1059E. Iron Eagle Drive Suite 175 Eagle, ID 83616*

Patient Name: _____
First MI Last

D.O.B. _____ (mm/dd/yyyy)

I request Health Services, LLC to accommodate the following request for confidential communications as indicated below:

This is a:
- ☐ New Request — Date: _____
- ☐ Withdrawal of Prior Request — Prior Request Date: _____
- ☐ Change to Prior Request — Prior Request Date: _____

Information for which confidential treatment is required: _____

Communication Type Requested:

☐ Mailing Address: _____
Street Address City, State Zip

☐ Telephone: _____

☐ Other: _____
(please be specific) _____

By signing this form I represent the information provided in this form is true and correct. I understand that this form only applies to the information and communication type reflected above. I understand that *[Business Name]* has the right to decline my request and will inform me of their decision.

_____
Patient/Representative Signature Date

If you are the Patient's Representative, please describe your relationship (i.e. power of attorney, legal guardian, etc.)

_____