TotalWell Health Clinic

A MULTISPECIALTY ORGANIZATION WITH A SINGULAR FOCUS: YOU

HIPAA PRIVACY RIGHTS REQUEST FORM

REQUEST FOR CONFIDENTIAL COMMUNICATIONS REGARDING MEDICAL INFORMATION

You have the right to request that we communicate with you privately about your medical care by alternative means or alternative locations than the contact information of the person who pays for your health insurance. Please provide us with your private contact information that you would like us to use. TotalWell Health Clinic will then take reasonable steps to accommodate this request.

I request that TotalWell Health Clinic communicate with me **confidentially** about my medical care in the following manner (check the box of your preferred contact information):

☐ **Address where you can contact me confidentially:**

Street Address: _____

City: _____

State:_____

Zip Code: _____

☐ **Email address to contact me confidentially:**

_____

☐ **Phone number to contact me during the day:**

_____

☐ **Phone number to contact me during the evening:**

_____

_____
Patient Printed Name

_____
Patient/Patient Representative Signature

_____
If Patient Representative, Relationship to Patient

_____
Date