NORTHRUP
& ASSOCIATES

CONFIDENTIAL COMMUNICATION REQUEST FORM

You have the right to request that Northrup & Associates, PC communicate with you on a confidential basis. By requesting an alternative means or an alternative location when communicating with you about protected health information (PHI). The practice will accommodate reasonable requests.

Patient Information:

Patient Name: _____ Date of Birth: _____

Home Phone: _____ and/or Cell Phone:_____ May we leave a voicemail: Yes or No **(circle one)**

Patient Address: _____
Street City, State, Zip

Alternative Confidential Communication:

Address to receive communications:

_____
Street City, State, Zip

Additional telephone numbers to receive communications:

Cell phone _____ May we leave a Voice mail: Yes or No **(circle one)**
Work number_____ May we leave a Voice mail: Yes or No **(circle one)**

Please list any individuals and their relationship to you that you request we use to communicate with you:
Ex: Spouse, Guardian, Relative, POA, HCPOA, Friend:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Do you have a POA, Living Will or HCOPOA for our records? Is so, please list their contact information
Name: _____ Phone: _____ Relationship: _____

Signature

I attest that all of the above statements on this request and all information furnished by me are true and complete to the best of my knowledge.

Signature _____ Date _____
Printed Name _____
Relationship if Not Patient _____