PLUMAS COUNTY, CALIFORNIA

REQUEST FOR RESTRICTION ON THE METHOD OF CONFIDENTIAL COMMUNICATIONS

Date:_____

Name:_____

Date of Birth:_____

You may request to receive confidential communications of protected health information by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

We may not ask you the reason for your request. We will accommodate all reasonable requests

If you make a special request, you must give us an alternative address or other method of contacting you (phone number, address, etc.). Please specify how or where you wish to be contacted:

_____

☐ Phone calls:_____

☐ Written communications:_____

Signature of patient or representative:_____

If representative, give relationship:_____