

**New Beginnings Pediatrics**

**Request to Receive Confidential Communications of Protected Health Information**

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding communication:

**APPOINTMENT CONFIRMATIONS:**

Yes  No      Leave message on my home answering machine  
Phone Number: \_\_\_\_\_

Yes  No      Leave message with persons at my home

**ALL OTHER INFORMATION:**

Yes  No      Contact me at my home

Yes  No      Leave message on my home answering machine

Yes  No      Leave message with persons at my home

Yes  No      Contact me at my work and or Cell  
If yes, OK to leave message?  Yes  No  
If yes, work number: \_\_\_\_\_  
If yes, cell number: \_\_\_\_\_

Yes  No      Send sealed confidential information to my home address

Yes  No      Send sealed confidential information to another address:  
\_\_\_\_\_  
\_\_\_\_\_

Other requests for confidential communications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(See other side of form for Patient identifying information)**

\_\_\_\_\_  
Patient (if >18years old) or Parent **Signature**

\_\_\_\_\_  
Date

New Beginnings Pediatrics

Identifying Information:

\_\_\_\_\_  
Patient (if >18years old) or Parent Name

\_\_\_\_\_  
Child Name (if applicable)

\_\_\_\_\_  
Child Name (if applicable)

\_\_\_\_\_  
Child Name (if applicable)

\_\_\_\_\_  
Child Name (if applicable)

\_\_\_\_\_  
Account Number (office use only)

\*\*\*\*\*

Patient Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from my  
physician.

\_\_\_\_\_  
Patient (if >18years old) or Parent Signature

\_\_\_\_\_  
Date