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)

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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