HIPAA Privacy Policy Patient Acknowledgement

I _____have reviewed a copy of Denver Back Pain Specialists Privacy Policy. I may request a paper copy and/or review the policy on the website.

Signature:_____ Date: _____

Confidential Channel Communication Request

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will try to accommodate all reasonable requests.

I, _____ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

Please select all that apply.

❑ **Phone**

I want you to contact me by telephone at _____

❑ Do ❑ Do not leave messages on my answering machine.

❑ Do ❑ Do not leave messages with any other person.

❑ **Mail.** I want you to contact me at the following address: _____

_____

❑ **Fax.** I want you to contact me at the following fax number: _____

❑ **Additional Contacts.** Please list the names of other parties (family members, friends, attorney, etc.) that you authorize Denver Back Pain Specialists to discuss your treatment/health with**:**

Name:_____ Relationship:_____

Name:_____ Relationship:_____

❑ **Other requests for confidential communications** (specify)**.**

_____

_____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient (or plan member), please indicate your relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient
☐ other (specify)

Name of Patient: _____