RESTOR PHYSICAL THERAPY
P.O. BOX 8125
FOUNTAIN VALLEY, CA 92728-8125
PHONE: 714-754-7268 FAX: 714-434-7042

Confidential Channel of Communication Request

As required by the Health Information Portability and Accountability Act of 1996 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 make every effort to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

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

What telephone number(s) may we use to contact you?

Home: _____ Cell: _____

What email address may we use for correspondence? _____

Please circle your choice response to the following questions:

May we leave messages concerning your appointments/treatment with a co-worker, receptionist, or secretary that regularly answers your calls? Yes No

May we leave messages on a voice mail at work? Yes No

May we leave messages on an answering machine at home? Yes No

May we leave information with a spouse or significant other? Yes No

Is there anyone that is not listed above that we can give information to? If so, please specify. Yes No

Name_____ Relationship _____
Name _____Relationship _____
Name _____Relationship _____

For any children above 18, still living at home, may we discuss your appointments/treatments? Yes No

You must inform us, in writing, of any changes in your directives. This record takes effect August 5, 2013 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

You may contact our privacy officer Robin R. Wells at (714) 754-7268.

Patient Name: _____Date:_____
(Please print)

Signature: _____ Date of Birth: _____