SANJIV GOEL, M.D., F.C.C.P, F.A.C.C.
2100 LYNN ROAD SUITE 205 • THOUSAND OAKS, CALIFORNIA 91360
PHONE (805) 497-3585 FAX (805) 497-1313

Confidential Channel 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 reasonable efforts 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, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ **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: _____

_____

☐ **E-mail**

I want you to contact me at the following e-mail address: _____

☐ **Fax**

I want you to contact me at the following fax number: _____

☐ **Other**

_____

_____

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☐ Check here if you agree to pay for the costs associated with your request for an alternate communication channel. These costs have been explained to you.

Signed: _____ Date: _____

Print Name: _____
If not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

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***For office use only*:**

Date Granted: _____

Date Terminated or Modified: _____