BVDA

CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

PATIENT REQUEST

I, _____(print name), request confidential communication of my protected health information in accordance with my rights under the *HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT* of 1996 (HIPPA).

Communications with the patient named above may also be directed to:

_____
Name

_____
Street Address

_____
City/State/Zip code

_____
Telephone Number

Is payment for the above referenced patient to be made by the person(s) listed above?:

- o YES
- o NO

_____
Patient's Signature

Date