KootenaiHealth

Confidential Communications Request Form

I, _____, request that my protected healthcare information including clinical information (e.g., test results, patient instructions), billing information, and other facility communications (e.g., patient surveys) be communicated to me via the alternate address/phone listed below. I understand that this request for Confidential Communications will apply to all future communications.

NOTE: ***Only U.S. addresses and phone numbers will be accepted. All information requested below must be completed in order for this request to be processed by Kootenai Health.***

Patient Name: _____

Street Address: _____

Suite/Apt. Number (if applicable) :_____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Phone Number: _____

Email Address: _____

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected/out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, the facility will communicate with me via other means and/or at other locations.

NOTE: ***This request only applies to communications for Kootenai Health. If you wish to request Confidential Communications from your insurance company, you must contact them directly.***

Patient/Patient Representative Signature:

Date: _____ Time: _____

If you have any questions about this form, please do not hesitate to contact me.

Kootenai Health
Privacy Officer
2003 Kootenai Health Way
Coeur d'Alene, ID 83814
208.625.6248

Facility use only:

Patient Med Record Number: _____ Patient Acct. Number: _____