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.

Patient Name: _____

Street Address: _____

Address Line 2: _____

City: _____State: _____ Zip Code: _____

Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Please note: Email messages are not always a secure form of communication. By selecting this method of communication and signing this form, you are accepting the risk of your information being sent in a way that may not be secure.

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.

_____ _____

Patient/Patient Representative Signature Date

If you have any questions about this form, please contact:

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