CONFIDENTIAL COMMUNICATION REQUEST FORM

Patient Name:____ Date of Birth: ____

I wish to be contacted in the following manner (check all that apply):

❑ Home Telephone # _________________________
- ❑ OK to leave message with detailed information
- ❑ Leave message with callback number only

❑ Work Telephone # ___________________________
- ❑ Ok to leave message with detailed information
- ❑ Leave message with callback number only

❑ Written Communication

❑ OK to mail to my home

❑ Patient Portal only (this is a secure communication)

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.

❑ Email Message Email address: ________________________________

❑ No restrictions necessary

I request my written patient information be communicated to me at the alternate address listed below:

Street Address: ____

City: ____________________ State: ______ Zip Code: __________

I allow Kootenai Health to discuss information with:

Spouse: ____ Phone # ____

Child: ____ Phone # ____

Parent: ____ Phone # ____

Caregiver: ____ Phone # ____

Additional Comments: ____

____

Patient Signature:____ Date: ____

FOR OFFICE USE ONLY:
Review this form with the patient, no less than annually. If patient would like to change these preferences, please complete a new form and scan to the medical record.

Patient Initials:____ Date Reviewed & Revised:________________________

Patient Initials:____ Date Reviewed & Revised:________________________