



**SOUTH DENVER CARDIOLOGY ASSOCIATES - A CENTURA HEALTH CLINIC
PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

Facility Name: _____

Patient Name	Date of Birth	Last 4 Digits of Social Security #
Address	City, State, Zip Code	Telephone Number

I hereby request that this Centura Health facility use an alternative location or alternative means for communicating with me related to my personal health, treatment or payment for treatment other than those Centura Health typically uses. This request supersedes any prior request for confidential communications I may have made. I understand that this request will remain in effect until I notify Centura in writing requesting a change.

I request that communications be made using the alternative means listed below (check and complete only those for which you prefer an alternative to what we already have on file):

PHONE – Alternate telephone number: _____
 DO DO NOT leave messages on my answering machine/voicemail
 DO DO NOT leave messages with any other person

MAIL – Alternate mailing address: _____

OTHER METHOD – Describe: _____

(If email is requested as other method) EMAIL – Email address: _____

SPECIFIC INSTRUCTIONS OR OTHER REQUESTS: _____

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Legal Guardian)

Name of individual signing on behalf of patient: _____

Relationship (if other than patient): _____

Verification: Drivers License # _____ Other Appropriate ID: _____

OFFICE USE ONLY

Name of individual who received request: _____ Date received: _____

Patient Medical Record #/Account #: _____ / _____ Completion date: _____

Request: Approved Denied Delivery Method: _____