Patient Sticker

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

EVERGREEN ENDOSCOPY CENTER, LLC

2400 TAMARACK AVENUE, SUITE 100

SOUTH WINDSOR, CT 06074

BILL WOLLMAN, PRIVACY OFFICER 860-644-7336

As required by the Health Insurance Portability and Accountability Act of 1996 you have the right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided.

I,_____(print name) hereby request the use of confidential channels for the communication of information related to my personal health, treatment, or payment for treatment as follows:

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

___**Phone**

I want you to contact me by telephone at _____

___Do ___Do Not leave messages on my answering machine or with any other person.

___**Mail**

I want you to contact me at the following address:_____

_____

___**Fax**

I want you to contact me at the following fax number:_____

___**Other** (Please indicate method of preferred communication if other than above)

_____

Signed:_____ Date:_____

Print Name:_____

If not signed by patient, please indicate signer's relationship to patient:_____