



Physical Therapy Institute

Dedicated to keeping you ACTIVE.

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act (HIPAA) of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. Professional Orthopedic and Sports Care (POSC) will not ask you why you are making your request, and we will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my *personal health, treatment, or payment* of treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

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

DIAGNOSIS & TREATMENT

I, ___ Do ___ Do not ___ want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

PHONE

I want you to contact me by telephone at: _____

___ Do ___ Do not ___ leave messages on my voice mail/answering machine.

___ Do ___ Do not ___ leave messages with any other person.

Please indicate name, if any, of individuals(s) approved to take above messages:

MAIL

I want you to contact me at the following address:

After Physical Therapy Discharge

I Do ___ Do not ___ want to be contacted regarding health programs, injury prevention classes, etc.

Print Patient Name: _____

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:

___ Parent or guardian of minor patient ___ Guardian or conservator of an incompetent patient

Name of parent, guardian, or conservator: _____