WESTGATE FAMILY MEDICINE
2015 Dean St. Unit 2
St. Charles, IL 60174
Phone (630) 584 -2400
Fax (630) 584-2404

Request to Receive Confidential Communications of Protected Health Information

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

PATIENT NAME: _____ DATE OF BIRTH: _____

Please indicate your request regarding communication:

APPOINTMENT CONFIRMATIONS:

___Yes ___No Leave message on my home answering machine

___Yes ___No Leave message with persons at my home

CONFIDENTIAL INFORMATION:

___Yes ___No Contact me at my home

___Yes ___No Leave message on my home answering machine

___Yes ___No Leave message with persons at my home

___Yes ___No Contact me on my cell

___Yes ___No Contact me at work If yes, OK to leave message? ___Yes ___No

___Yes ___No Send sealed confidential information to my home address.

If **no**, list another address.

_____

Other request for confidential information:

_____

_____

Parent (if >18 years old) or Parent **Signature** _____ Date: _____

WESTGATE FAMILY MEDICINE

Identifying Information:

Patient (if >18 years old) or Parent Name: _____

Child Name (if applicaple) _____

Child Name (if applicable) _____

Child Name (if applicable) _____

Child Name (if applicable) _____

Account Number (office use only) _____

Patient receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices from my physician.

Patient (if >18 years or older) or Parent Signature: _____

Date: _____