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Patient Request for Confidential Communications

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Under emergency situations, AdvantageCare Physicians will first attempt to communicate with me as requested above. If unable to contact me, AdvantageCare Physicians will attempt to reach me by other means. I understand that signing this request is voluntary. Treatment, payment, enrollment or eligibility for benefits <u>may</u> <u>not be conditioned</u> on whether I sign this request. Completed forms may be:

- 1. Dropped off at an AdvantageCare Physicians medical office site with Attention to: Practice Administrator or
- Mailed to: Privacy Officer AdvantageCare Physicians 55 Water Street, 12th Floor, Rm 12H92 New York, NY 10041

Signature Patient or Authorized Representative

Date

Print Name of Patient or Authorized Representative

Relationship to Patient or Authority of Authorized Representative

For ACP Use Only

Date Received: (MO/DY/YR) ___/___/

Received by (print): ______

Scanned to HIM by Medical Office

Disposition of Request: ____GRANTED ___ DENIED (Notify Requestor