Children's of Alabama

CHILDREN'S OF ALABAMA
REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

Patient Information

Patient Name: (Please print)		**Request Date:**	
Street Address:		**Birth Date:**	
City/State/Zip:		**Phone Number:**	

Request for Confidential Communications

Method to Communicate Patient's Health Information (if different from above):	
Dates of Service Requested:	I am requesting confidential communications for the patient's records with the following dates: From: To:
Please describe confidential communication you want to happen:	

Signature of Parent/Legal Guardian/Patient

I represent that I am the parent/legal guardian of the patient and have the authority to request this confidential communication. I understand that COA may not be able to accept this request if prohibited by law.

Parent/Legal Guardian Print Name:_____

Parent/Legal Guardian Signature:_____Date:_____

Patient Signature if 19 or older:_____Date:_____

Witness Signature:_____Date:_____

** RETURN FORM TO THE COA PRIVACY OFFICER**
Mailing Address: COA Privacy Officer, Children's of Alabama, 1600 7th Avenue South, Birmingham, AL 35233
Fax: (205) 638-2468
Email: HIPAA@ChildrensAL.org
Phone for Questions: (205) 638-5959