



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