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:		**Date of Service:**	

Request for Confidential Communications	
Address to Send Patient's Health Information (if different from above):	
Dates Requested:	I would like confidential communications for patient records with the following dates: From: To:
Please describe what you want to happen:	

Signature of Parent/Legal Guardian/Patient

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

Parent/Legal Guardian Signature:_____ **Date:**_____

Patient Signature if 14 or older:_____ **Date:**_____

Witness Signature:_____ **Date:**_____

INTERNAL USE ONLY:
IMPORTANT: PLEASE PLACE VISIBLY IN RECORD. ROUTE COPY TO HIPAA OFFICE.
Date Received:_____ Date Sent:_____
Comments:_____
Caregiver Processing Request:_____MIS Initials:_____HIPAA Initials:_____