Institute for Beauty, Wellness & Regenerative Medicine

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request and will make every effort to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ ***(print name)*** hereby request the use of the following confidential channels for the communication of information related to my personal health or treatment. This request supersedes any prior request for confidential channel communications I have made.

What telephone number(s) may we use to contact you? _____

What email address may we use for correspondence? _____

Please circle your choice response to the following questions:

May we leave messages concerning your appointments/treatment with a co-worker, receptionist, or secretary that regularly answers your calls? Yes No

May we leave messages on a voice mail at work? Yes No

May we leave messages on an answering machine at home? Yes No

May we leave information with a spouse or significant other? Yes No

Is there anyone that is not listed above that we can give information to? If so, please specify.
Yes No
Name _____ Relationship _____
Name _____ Relationship _____

For any children above 18, still living at home, may we discuss your appointments/treatments?
Yes No

You must inform us, in writing, of any changes in your directives. This record takes effect January 1, 2009 and will be kept in your file along with your acknowledgment of receipt of our Notice of Privacy Practices.

I hereby acknowledge that I have been presented with a copy of the Institute for Beauty, Wellness & Regenerative Medicine's Notice of Privacy Practices.

Patient Name: _____ Date: _____
(Please print)
Signature: _____
(If minor or disabled, Legal Guardians signature)

NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you