DIABLO VALLEY
PERINATAL ASSOCIATES

CONFIDENTIAL COMMUNICATION PREFERENCE

Please Print
PATIENT NAME: _____ DATE OF BIRTH_____/_____/_____

You may request to receive confidential communications of Protected Health Information in the method you prefer or at an alternative address. For example, you may not want your appointment notices to be mailed to your home where it might be seen by others.

PROTECTED HEALTH INFORMATION (PHI)
PLEASE CIRCLE OR FILL IN THE ANSWER THAT APPLIES FOR EACH QUESTION

- **Laboratory, X-ray, test results, billing statements and/or any correspondence pertaining to Protected Health Information (PHI).**

Do you authorize Dr./NP./Group or their staff members to contact you and/or leave messages, as described above, at the following numbers? **L/M=Leave Message**

Home Phone	(____) _____	Yes	No	N/A	L/M to return call only
Work Phone	(____) _____	Yes	No	N/A	L/M to return call only
Cell Phone	(____) _____	Yes	No	N/A	L/M to return call only
Other Phone	(____) _____	Yes	No	N/A	L/M to return call only

Do you wish to be the ONLY person authorized to receive your Protected Health Information? Yes/ No

Below, please list any other person(s) you would like to authorize to be able to receive you Protected Health Information (PHI).

_____
Name Phone Number Relationship to Patient

_____
Name Phone Number Relationship to Patient

- **Correspondence:**

Any correspondence related to your Protected Health Information will be automatically mailed to your **home address,** as indicated in our files.

Do you agree to this? Yes No If No, please provide alternate address:

_____
Address City State Zip Code

Thank you for assisting us to serve you more effectively by providing the above direction regarding your privacy wishes.

_____ _____/_____/_____
PATIENT SIGNATURE DATE