

HIPAA PRIVACY RIGHTS REQUEST FORM

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS
REGARDING MEDICAL INFORMATION**

You have the right to request that we communicate with you privately about your medical care by alternative means or alternative locations than the contact information of the person who pays for your health insurance. Please provide us with your private contact information that you would like us to use. Nicole Hraniotis, M.D., LLC will then take reasonable steps to accommodate this request.

I request that Nicole Hraniotis, M.D., LLC communicate with me **confidentially** about my medical care in the following manner (please **indicate ALL forms of contact below**, and then **check the box of your preferred contact information**):

Address where you can contact me confidentially:

Street Address:

City:

State:

Zip Code:

Fax Number:

Phone number(s) to contact me during the day:

Phone number(s) to contact me during the evening:

Patient Printed Name

Patient/Patient Representative Signature

If Patient Representative, Relationship to Patient

Date