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PrairieShorePainCenter.com

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. PrairieShore™ Pain Center will then take reasonable steps to accommodate this request.

I request that PrairieShore Pain Center communicate with me confidentially about my medical care in the following manner:

Check the box of your preferred contact information.

Address where you can contact me confidentially:

Street Address: _____

City: _____

State: _____ Zip Code: _____

Email address to contact me confidentially: _____

Phone number to contact me during the day: _____

Phone number to contact me during the evening: _____

Patient Printed Name

Patient/Patient Representative Signature

If Patient Representative, Relationship to Patient

Date