OPTOMETRY SERVICES

CONFIDENTIAL COMMUNICATION REQUEST FORM

You have the right to request that we communicate with you on a confidential basis by requesting an alternative means or an alternative location to receive our communications. We will accommodate all reasonable requests for confidential communication. If you wish us to contact you at an address or phone number other than your home address or telephone, please provide us with the following information:

PATIENT INFORMATION

Name _____ Date of Birth _____/_____ / _____

Street Address _____

City _____ State _____ Zip _____

Phone_____ E-mail Address_____

Address to receive communications: Phone number to receive communications:

Name _____ _____

Street _____

City_____ State_____ Zip Code _____

Please describe in as much detail as possible any other alternative means you request we use in communicating with you or any other alternative location not detailed above.

_____

_____

_____

_____

Do you believe that without this alternate communication, the disclosure of some or all of your information could endanger you?

_____Yes _____ No

_____ _____

Signature **Date**

If you are a personal representative of a patient, please provide documentation or explanation of your authority to act for the patient/client and attach to this form. Please note that we will not process any requests that are not signed by you or your personal representative.

Return this form to the HIPAA Privacy Officer, The Ohio State University College of Optometry, 1664 Neil Ave., Columbus, OH 43201, 614-292-2020.

THE OHIO STATE UNIVERSITY
COLLEGE OF OPTOMETRY

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