

**Malhotra Center for Plastic Surgery, PC**

**Confidential Communication Request**

**Acknowledgement of Receipt of Notice of Privacy Practice**

*As required by Health Information Portability and Accountability Act of 1996 you have the 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 reasonable efforts to accommodate all reasonable requests. Some methods 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 supercedes any prior request for confidential communications I have made.

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

What email address may we use for correspondence? \_\_\_\_\_

May we discuss pertinent information with anyone else?      YES      NO

If yes, please state name and relationship to you:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

By signing below, I hereby authorize my health information, as more specifically described as a medical record or protected health information, to be used or disclosed at my request to the above named, Dr. Malhotra's staff, and my primary or referring physician.

**I hereby acknowledge that I have been presented with a copy of Malhotra Center for Plastic Surgery Notice of Privacy Practices.**

**Patient Name: (please print)** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(If minor or disabled, Legal Guardian signature)