

Request to Confidential Communications

Individual Name: _____

Individual Address: _____

Individual Date of Birth: _____

Individual SSN: _____

Specimen ID # (if known) _____

Please consider this a request for me to exercise my rights under federal and state laws to request confidential communication of any protected health information.

Check all that apply to this request:

- Please do not phone me at home. Use this alternate phone number to contact me: _____
- Please do not phone me at work. Use this alternate phone number to contract me: _____
- Please send my mail to this alternate address:

- Please do not leave messages on any answering machine.
- Please do not contact me by phone.

I understand that the provider to whom I am making this request will make reasonable efforts to accommodate this request. I understand that I must provide an alternate address to receive bills and statements. I further understand that in some emergency situation, my protected health information may be released.

Signature: _____ *Date:* _____

Please Mail Form to:

Clinical Reference Laboratory, Inc. Attn: Privacy Officer, 8433 Quivira Road Lenexa, KS 66215