CLINICAL REFERENCE® LABORATORY

Request for Confidential Communications

Effective date of this notice: 04/16/2020

Individual Name: _____
Individual Address _____
Date of Birth: _____
SSN: _____
Specimen Identification No: _____

Please consider this a request for the exercise of my rights under federal and state laws to request confidential communications of my Personal Information

Describe the Personal Information you would like subject to alternative communication

Check all that apply to this request
☐ Please do not contact me by phone.
☐ 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 contact me: _____
☐ Please do not leave message on any answering machine or voicemail.
☐ Please do not text me.
☐ Please only text me at this number: _____
☐ Please send my mail to this alternate address: _____ _____ _____

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, if applicable. I further understand that in some emergency situation, my personal information may be released.

Signature: _____ Date: _____

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