Ivette E. Diaz, MD., LLC
304 Federal Road,
Suite 201
Brookfield, CT 06804
Phone Nº: (203) 740-2593 Fax Nº: (203) 740-8250

Confidential Communications Request
&
Acknowledgement of Receipt of Notice of Privacy Practices

As required by the health Information Portability and Accountability Act of 1996 (HIPAA), you have the right to request that communications concerning your personal health information be made through confidential channels. The staff of Ivette E. Diaz. M.D.,LLC will not ask you why you are making this request, and will make reasonable efforts to accommodate you. Some method of contact must be provided.
I_____ (print your name) hereby request the use of confidential channels for communication of information related to my personal health, treatment, or payment for treatment.

Effective Date _____

This authorization will remain valid until revoked in writing.

Please select the ACCEPTABLE forms of communication:

- o Home Telephone: _____ o Cell/Mobile:_____
- o Work Telephone. _____ o Pager: _____

Please list the names of ACCEPTABLE people with whom Dr. Diaz' staff may discuss your protected health information (please print name of person):

- o None, please speak only to me.
- o Spouse:_____ Telephone._____
- o Family. Member: _____ Telephone:_____
- o Parent _____ Telephone:_____
- o Friend: _____ Telephone:_____
- o Other (lawyer, etc):_____ Telephone:_____

In the event you do not answer your contact telephone number, Dr. Diaz' staff:

- o May leave a message on your answering machine.
- o May not leave a message.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature of Patient: _____ Date:_____

If form is completed by person other than patient:

Signature _____ Date:_____

Relationship to Patient: _____

FOR OFFICE USE ONLY
If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

By:_____ Date/Time. _____