UROLOGY CENTER OF COLUMBUS, L.L.C.

Request for Confidential Communication of PHI

Name of Patient: _____

Patient Date of Birth: _____ Date of Request: _____

Please indicate how you would like the practice to communicate with the patient:
(e.g. alternate address, alternate phone, email)

_____

_____

_____

The following communications should be provided via the method described above:

_____

If this request limits the practice's ability to collect payment for services rendered, I agree to be responsible for paying the bill in full. If I fail to pay the bill within 30 days, I agree to allow the practice to contact me at any other known addresses or phone numbers for purposes of seeking payment.

_____ _____
Patient Signature or Personal Representative Date

Office Use Only

Request was received by: _____ Date:_____
(Name and title of staff receiving / processing this request)

- ❑ **We hereby accept this request.**
- ❑ **We hereby deny this request.**

_____
Practice Representative (Type/Print)

_____
Practice Representative Signature

_____
Date