Cosmetic & Reconstructive Dentistry

1275 Post Rd
Fairfield, CT 06824
(203) 255-6878

Confidential Communication Request

Patient Name: ____________________________ Date of Birth: ______________

I would like to receive communications of my protected health information from this practice by alternative means or at an alternative location.

The information I would like communicated by alternate means or to an alternate means or alternate location is:

- ❑ All Information
- ❑ Other (specify)____________________________________

I request my information be delivered in the following manner:

- ❑ Us postal service other than First class Mail (please specify) __________
- ❑ Express/overnight delivery (special preferred carrier)________________
- ❑ Email Address ____
- ❑ Other (specify)____

I request information is delivered to the following valid mailing address or location: ____

I understand that I may be required to pay this practice for any non-customary expenses incurred to satisfy my request, and that the address provided is correct and capable of accepting my information. I will be notified and must agree in advanced to pay the cost of the alternate communication. The practice reserves the right to deny requests that impose an unreasonable cost or burden.

Signature: ______________________________ Date: ________________
Relationship to patient: _______________________________

For Office Use

☐ Accepted ☐ Declined Date: ________________ By: ____________________