

Connecticut Neck & Back Specialists, LLC

20 Germantown Road
Danbury, CT 06810
Tel: 203 744 9700
Fax: 203 744 9701
www.ctneckandback.com

David L. Kramer, M.D.
David A. Bomback, M.D.
Jennifer Madonia-Barr, PA-C

CONFIDENTIAL COMMUNICATIONS REQUEST AUTHORIZATION

As required by the Health Information Portability and Accountability Act of 1996 (**HIPPA**), you have the right to request that communications concerning your personal health information be made through confidential channels. The staff of **Connecticut Neck & Back Specialists, 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 of treatment.

Effective Date: _____

This authorization will remain valid until revoked in writing:

Patient's Home Telephone: _____

Patient's Work Telephone: _____

Patient's Cell Telephone: _____

Please initial the **ACCEPTABLE** forms of communication:

_____ None; please speak **ONLY** to me

_____ Spouse's Name & Telephone # _____

_____ Family Member Name & Telephone # _____

_____ Parent's Name & Telephone # _____

_____ Friend's Name & Telephone # _____

_____ Other (Attorney, etc.) Name & Telephone # _____

In the event you do not answer your contact telephone number, **Connecticut Neck & Back Specialists, LLC** staff (Please initial):

_____ May leave information on your answering machine regarding results and recommendations.

_____ May **NOT** leave information on your answering machine. If this is checked, it is the Patient's responsibility to contact the office.

_____ May leave message on answering machine to return call to office.

Signature of Patient

Date

If form is completed by person other than Patient:

Signature

Relationship to Patient _____

Date