# Connecticut Neck & Back Specialists, LLC

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## Request for Confidential Communications

**PATIENT INFORMATION:**

Patient Name: _____ Patient Date of Birth: _____

Patient Address:_____

Patient Phone: _____ Patient email: _____

I hereby request that any communications made by this practice to me be made:

☐ By alternative means (specify in space below):

_____

_____

☐ At an alternative address (specify in space below):

_____

_____

I would like all future communications to me to be made in accordance with my wishes as expressed above. I understand that if I refuse to specify an alternate address or to provide information as to how payment, if any, will be handled, this practice may deny my request.

Authorized & Accepted By (Privacy Officer or Designee):

_____ _____

Signature of Patient On behalf of Connecticut Neck & Back

_____ _____

Date Date

☐ Check when notation has been made in patient's record