



# REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Requesting Confidential Communication:

Relationship to Patient (if not patient): \_\_\_\_\_

- I request no special communication procedures.
- I request that Angels Grace hospice communicates with me confidentially about medical matters in the following manner:

*Describe how you wish Angels Grace Hospice to contact you (e.g. only by phone at work? At home?)*

- Home Phone ( ) \_\_\_\_\_ Answering Machine: Yes \_\_\_\_\_ No \_\_\_\_\_
- Work Phone ( ) \_\_\_\_\_ Leave Message: Yes \_\_\_\_\_ No \_\_\_\_\_
- Cell Phone ( ) \_\_\_\_\_ Leave Message: Yes \_\_\_\_\_ No \_\_\_\_\_
- Other Phone ( ) \_\_\_\_\_ Leave Message: Yes \_\_\_\_\_ No \_\_\_\_\_
- Fax ( ) \_\_\_\_\_

Special Instructions for Fax:

- List specific persons information is not to be communicated to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Angels Grace hospice will accommodate all reasonable requests. If you cannot be reached as requested, Angels Grace Hospice may, as necessary, use other means to contact you.**

\_\_\_\_\_  
Signature of Patient or Legal Representative Date: \_\_\_\_\_

\_\_\_\_\_  
Please Print Name