REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

New River Family Wellness, PLLC
420 East Second Street, West Jefferson, NC 28694

Patient Name: ____ **MR#:** ___________________
has requested confidential communication of protected health information.

Designated Method of Contacting Patient:
Communications with the patient named above should be directed to:

____
Mailing Name

____
Street Address

____
City State Zip Code

____
Telephone Number

Alternative Arrangements for Payment:
Payment for services provided to the patient will be made as follows (describe payment arrangement):

____

____

____

PRINTED NAME: ____ **DATE:** ___________

Patient Signature: ____