REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient's Name: ________________________________ Birth Date: _______ /_______/______
MM / DD / YR

Address: ____
____

Home Telephone Number: ________________ E-mail: ________________________________

Patient's Medical Record Number and/or Social Security Number: ______________________

I, ____, am requesting that Koru Medical communicate with me in the alternative manner and/or location described below regarding my health information. I understand that Koru Medical may deny this request if it imposes an unreasonable administrative burden.

Description of the health information that must be communicated confidentially. The following is a description of the specific health information to which this request applies:

____

____

Alternative Manner and/or Location. I request that Koru Medical only communicate with me in the following manner and/or at the location described below:

____

____

By signing this form, I am confirming that it accurately reflects my wishes.

____ ______/______/______
Signature Date

If signed by personal representative:
Name of personal representative: ____

Relationship to participant or nature of authority: ________________________________

____ ______/______/______
Signature of Personal Representative Date

Please Submit Form to: Koru Medical

Vivian Chin, MD, MPH
Medical Director
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917-773-8878