Alternative Confidential Communication Request Form

CLIENT INFORMATION

Client Name:		Request Date:	
Street Address:		Birth Date:	
City/State:		Zip:	
Telephone #:		Social Security #:	

PERSON REQUESTING ALTERNATIVE CONFIDENTIAL COMMUNICATION

Name:		Telephone #:	
Street Address:		Alt. Telephone #:	
City/State:		Zip:	
Relationship to Client:			

ALTERNATIVE CONFIDENTIAL COMMUNICATION REQUEST

Please indicate the alternative method by which you are requesting transmission of client information:

Unencrypted Email:	☐ Yes ☐ No
Email Address:	
Other:	
Describe:	

Your signature below documents understanding and acceptance that this request for communication by alternative means is not Tabitha's standard practice and that sharing protected information by alternative means is contrary to good security practices. Tabitha will not be responsible for any disclosures or breaches of health information resulting from the transmission of protected information as requested.

By: _____ Date: _____

Signature of Client or Client's Personal Representative

_____

Printed Name: Client or Client's Personal Representative

Tabitha: Internal Use Only----------

Date: _____ ☐ Approved ☐ Denied, Client Notified

Signature of Privacy Official or Designee: _____