



Request for Confidential Communication

I, _____, hereby request
Name of Patient / *Date of Birth*

Cancer Care Specialists of Illinois to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone:	CCSI can contact me by phone:	YES	NO
	Leave message on answering machine:	YES	NO
	Leave message with any other person:	YES	NO
Email:	CCSI can contact me through email:	YES	NO
	Email address: _____		
Mail:	CCSI can contact me at the address on file:	YES	NO
	For change of address or special request, please write below:		

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize the practice and my healthcare provider, or a business associate of theirs, to contact me at any of the numbers or email addresses using an automatic telephone dialing system, using a pre-recorded voice or other third-party automated outreach and messaging system as well as to use my protected health information, or other personal or identifying information, during such contact for any administrative or healthcare matter. I consent to the practice, my provider, or their business associate contacting me via unencrypted email and text messages. I also agree that they may leave detailed messages on my voice mail, answering system, or with another individual if I am unavailable at the number provided by me.

Contacts: Please list any Family/Personal Contacts that CCSI has permission to communicate with:

Name	Relationship	Phone Number

Other Requests for Communications: _____

I request the following restrictions: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____