southeastern virginia health system quality healthcare within reach

Request for Confidential Handling of Health Information

I, _____ (Print Patient Name), request confidential handling of correspondence regarding my health information for the period:

from _____to _____.

This request applies to health information involving _____
(please be as specific as possible, e.g., treatment regarding a given illness or diagnosis)

I, _____, give authorization to _____
to have access to any/all medical information.

Do you wish confidential handling of billing matters pertaining to the information described above?
Yes_____ No_____
If yes please sign the following:

Patient Signature: _____ Date: _____

I have selected to receive confidential information communications in the following way:

_____Patient will pick up confidential information communications in the provider's office.
_____Patient will receive any information at an alternate mailing address.

PLEASE USE THE FOLLOWING MAILING ADDRESS FOR ALL HEALTH INFORMATION COMMUNICATIONS THAT FALL IN THE DESCRIPTION PROVIDED ABOVE.
Print Mailing Address:
_____

City_____ State _____ Zip Code _____

If you have any questions concerning this confidential handling please contact:

_____ at (_____) _____
Name of medical records representative Phone number

_____ _____
Signature of medical records representative Date

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