REQUEST FOR CONFIDENTIAL COMMUNICATIONS

PATIENT NAME:
PATIENT ADDRESS:
TELEPHONE NUMBER:
DATE OF BIRTH:
NAME OF MCLAREN FACILITY:
(OR) NAME OF MCLAREN PROVIDER:

I, ___________________________________, request that McLaren Health Care communicate with me in the following ways (check all that apply and provide detail):

☐ Phone:	
☐ Mail:	
☐ Email:	* Note that sending patient information via e-mail may not be a secure means of communication.

I am requesting that McLaren NOT contact me at the following phone number and/or address:

____

Please provide any additional information to assist McLaren with the requested communication restriction:

____

Signature of requestor: ____ Date: ____/____/____

Printed name of requestor: ____

If requestor is a legal representative of patient, state the relationship to the patient or the nature of the legal authority:

Send completed form to:

MCLAREN HEALTH CARE PRIVACY OFFICER

One McLaren Parkway, Grand Blanc, MI 48439; or

Privacy@McLaren.org

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