McLaren
HEALTH CARE

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 requester: _____ Date: _____/_____/_____

Printed name of requester: _____

If requester 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

Privacy@McLaren.org

MHCC-192
(MHC_CC1108.7.7)
(5.25)

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PT.

MR.#/RM

DR.