

# Confidential Channel Communication Request

**Michael P. Bernstein, MD**  
146 Hazard Ave.  
Enfield, CT. 06082

Title name and telephone number of privacy officer:  
**Kellyann J. Cardinale**  
860-763-3243

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided.

I, \_\_\_\_\_ (print name) hereby request the use of confidential channels for the communication of information related to my personal health, treatment or payment for treatment as follows.

**Please check off all that apply.**

**PHONE** I want you to contact me by telephone at:

Home number \_\_\_\_\_, and/or  Work number \_\_\_\_\_

**Do** or  **Do Not** Leave messages on my answering machine or with any other person.

**Mail**

I want you to contact me at the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Fax**

I want you to fax my information to my attention the following number: \_\_\_\_\_

**Other**

**Please list any other person's full name and relationship to you that you give the office of Dr. Michael Bernstein permission to discuss your health information with. (such as, husband, wife, children, caregiver, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient: \_\_\_\_\_