COUNTY OF ORANGE, CA HEALTH CARE AGENCY **REQUEST FOR RESTRICTION ON THE** MANNER/METHOD OF CONFIDENTIAL

COMM	UNICATION	I		
Photocopy/Facsimile may be used as an original				
CLIENT/PATIE	NT INFORMATI	ON:		
NAME:				
AKA:	Last	First	М	
SOC. SEC.#:		DATE OF BIRTH		
20		turn this completed form for process, Suite 125, P.O. Box 355, Santa	-	stodian of Records office: 2, Phone (714) 834-3536, Fax (714) 835-9312
You may request to receive confidential communications of PHI by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.				
We may not ask you the reason for your request. We will accommodate all reasonable requests.				
If you make a special request, you must give us an alternative address or other method of contacting you (phone number, e-mail address, etc.). Please specify how or where you wish to be contacted:				
For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at http://www.ocgov.com/hipaa/forms.htm or by sending a written request to the address shown above.				
If you believe your privacy rights have been violated, you may file a complaint with the County of Orange or with the Secretary of the Department of Health and Human Services. To file a complaint with County of Orange, contact the HIPAA Privacy Officer at (714)834-5172 or visit our website.				
All complaints must be submitted in writing. You will not be penalized for filing a complaint.				
TODAY'S DATE:		SIGNATURE:		
PRINTED NAME:				
RELATIONSHIP:	Choose One: Cl	ent/Patient	ırdian 🗌 Repre	esentative
COMPLETE ADD	RESS: Street Add	ress	City Stat	TELEPHONE #
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IDENTIFICATION IMPRINT