

F-1003 HIPAA – Restricted Communication Request
PATIENT INFORMATION

		Date
Name (Last, First, Middle initial)		Date of Birth
Street address, City, ST, ZIP Code		Email address
Primary phone number Other phone number		Fax number

Communication change affects: (Select all that apply)

- ☐ Mailing Address
- ☐ Primary Phone
- ☐ Other Phone
- ☐ Email
- ☐ Voicemail
- ☐ Other (Specify below)

Please describe the restriction/accommodation requested in detail.

Alternative means of contact (Only if applicable to request)

Name (Last, First, Middle initial)	
Street address, City, ST, ZIP Code	
Email address	
Primary phone number Other phone number	
Fax number	

Please list Plan2Peak, Inc. staff member that was contacted regarding this matter:

Name of Plan2Peak, Inc.	staff member	Date
Patient (or legal health representative) Signature		Date

(Attach additional documentation, if applicable.)

For Administrative Use Only:

Date received

Action taken

Date

Action taken

Date

HIPAA Compliance Officer Signature

Date