
Request for Confidential Handling of Health Information

(HIPAA Compliant: 4/03)

I, _____ request that Blue Ridge
(First and Last Name of patient/recipient)

Neuropsychological Associates, P.A. handle my confidential health information in the following way:

- A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

- B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

Date: ____/____/____

Signature of client or guardian

Relationship of person signing

Witness