McLaren
HEALTH CARE

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

PATIENT NAME:	
PATIENT ADDRESS:	
TELEPHONE NUMBER:	
DATE OF BIRTH:	

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 requestor: _____ Date: ____/____/____

Printed name of requestor:
_____

If requestor 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; or
Privacy@McLaren.org