



DEPARTMENT OF MENTAL HEALTH

CLIENT'S REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Note: This form applies only to requests for confidential communications, i.e., when an individual is requesting a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify DMH of a change in address or other contact information.

Client Name: _____

Date: _____

Date of Birth: _____

MIS #: _____

You have the right to request to receive confidential communications of health information by alternative means or at alternative addresses. For example, if you do not want your appointment notices or your bills to go to your home where a family member might see it, you may ask us to communicate with you by another method or at an alternative location, such as a post office box.

We will not ask you the reason for your request. We will accommodate all reasonable requests to receive communications from us by alternative means or at alternative locations.

If you ask us to communicate with you in a different manner or at a different location than we are now using, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). Please specify how or where you wish to be contacted:

Alternate Address (postal or email):

New Phone Number (include area code):

Indicate what method of communication NOT to use: _____

Signature of client or representative: _____

If representative, give relationship: _____

APPROVAL

Signature of Treatment Provider: _____

Date: _____