Saint Luke's Health System

Request for Confidential Communications

Current Patient Information

Patient Name: ______________________ MR# ____________ Date of Birth: ______________

Address: ______________________________________ Phone: ______________

City: ______________________ State: ____________ Zip: ______________

Alternate Communication

Address: ______________________________________ Phone: ______________

City: ______________________ State: ____________ Zip: ______________

Effective Date: ______________________

Patient Signature: ____________________________________ Date: ______________

For Organizational Use Only

Received By: ______________________ Title: ______________________

Date Received: ______________________

________ **Accepted** Notified the following departments:	________ **Denied** Reason for Denial:

Original: File in Medical Record