FORM-2517-A

North Sound Mental Health Administration
117 North First Street, Suite 8
Mount Vernon, WA 98273
(360)-416-7013

Request for Confidential Communications Form

I, ______________________________, request confidential communication of my health information when my health information is disclosed on my behalf.

Please use the following address or manner in disclosing my health information to me.
(Please be as specific as possible.)

____
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____

Consumer Signature: ____

Date: ____

Printed Name and Date of Birth: ____

Effective Date: ____

Response to Request

_____ Agrees to entire request

_____ Denies part of requested action: ______________________________________

_____ Require more complete/specific information to assess your request

_____ The NSMHA cannot reasonably accommodate your request

Signed: ____

Title: ____

Date: ____