



Crossville Medical Group Professional Association

100 Lantana Road, Suite 202, Post Office Box 548, Crossville, TN 38557

(931) 484-5141
www.cmcmd.net



Request for Confidential Handling of Health Information

I, _____ (Print Name), request confidential handling of correspondence regarding my health information for the period:

FROM: _____
TO: _____

This request applies to health information involving:
Please be a specific as possible, e.g., treatment regarding a given illness or diagnosis.

Do you wish confidential handling of billing matters pertaining to the information described above?
___ Yes ___ No

I have selected to receive confidential communications in the following way:
___ Patient will pick up communications at the provider's office.
___ Patient will receive any information at an alternate mailing address.
Please use the following mailing address for all health information communications that fit in the description provided above:

PRINT MAILING ADDRESS:

CITY: _____ STATE: _____ ZIP CODE: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

___ We agree to honor your request;
___ We cannot honor the request. Reason: _____

If you have any questions concerning this confidential handling, please contact:

Signature of Supervisor of Nursing or your physician (931) 484-5141 DATE: _____