



**REQUEST FOR CONFIDENTIAL COMMUNICATIONS
REGARDING MEDICAL INFORMATION**

I request that the UT Health Science Center at San Antonio (Health Science Center) communicate with me confidentially about medical matters in the following manner:

(Please complete only the sections that apply to your request. Please include the area code and phone numbers and/or the full address of the location where we may contact you. We will not require that you disclose the reason for the request. We will accommodate all reasonable requests. If you cannot be reached at the designated alternative location you specify, the Health Science Center may use other means to contact you for payment.)

Address where you can contact me:	_____

Phone number where you can contact me during the day:	
Phone number where you may contact me after regular business hours:	
Fax number where you can contact me:	
How do you want us to handle your bill?	_____

Patient Printed Name

Patient/Patient Representative Signature

Date

If Patient Representative, Relationship to Patient