

# Request for Confidential Handling of Health Information

I, \_\_\_\_\_ request that  
(First and Last Name)

Lisa Cloyd, Ph.D. handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

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B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(City) (State) (Zip Code)

\_\_\_\_\_  
(Signature) (Date)