Texas Tech University Health Sciences Center

Confidential Communication Request
And
Identity Theft Protection Questions

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

❑ Permission to give verbal protected health information or leave messages with the following person(s):
Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care.

Make sure patient does not put providers.

Name: _____ Relationship: _____ Phone

Name: _____ Relationship: _____ Phone #: _____

❑ Permission to call the following numbers to leave messages (without disclosing protected health information):
Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.

Make sure these numbers are in the system.

Phone #: _____ Phone #: _____

❑ Permission to use e-mail address for the purpose of surveys only.
TTUHSC will not communicate via e-mail any patient health care or billing information.

HSC OP 56.02

E-mail address: _____

Security and Identity Theft Protection Questions: P

This area is for the patient to provide us with security and identity protection questions much like the banking industry. Reason is for TTUHSC to help protect the patient from identity theft or somebody obtaining information about them that is not authorized. The answers to these questions need to only be known to the patient and/or parent. Not the people listed above on form.

1. What was the name of the elementary school you at
2. What is your mother's maiden name? _____
3. What model was your first car? _____
4. What town were you born in? _____

Date	**Print Name**	**Signature** **(Patient or Other Legally Authorized Person)**
	Witness/Translator	**Relationship to Patient**