

Texas Tech University  
Health Sciences Center

Confidential Communication Request

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 (including appointment information) and 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. The patient and individuals listed below must provide at least one of the following: patient's address, patient's date of birth, last four digits of the patient's Social Security number.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**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.**

Please complete the following questions for additional level of security which staff may ask if they have concerns on releasing your information. **Please provide at least one answer.**

1. What was your mother's maiden name? \_\_\_\_\_
2. What town were you born in? \_\_\_\_\_
3. What is your grandmother's name? \_\_\_\_\_
4. What is the name of your first pet? \_\_\_\_\_

\_\_\_\_\_ **Date**

\_\_\_\_\_ **Print Your Name and Relationship to Patient  
(Person signing consent form)**

\_\_\_\_\_ **Signature  
(Patient or Other Legally Authorized Person)**

\_\_\_\_\_ **Relationship to Patient**

