URBANCARE
INTERNAL MEDICINE
& PEDIATRICS

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____, hereby request UrbanCare, LLC to keep communications
(Name of Patient or Authorized Agent)

regarding my protected health information confidential. To accomplish this request please adhere to the following requests.

Our preferred method of communication is through our secure patient portal. Providing your email address allows us to invite you to join our portal.

Email: _____

Phone: UrbanCare, LLC may contact me by phone at:

Home Phone: _____ and/or Cell Phone: _____

Select one:

☐ **Yes** ☐ **No** **UrbanCare, LLC may leave messages on answering machine**
Please note we will leave messages regarding your appointments.

FAX: UrbanCare, LLC may contact me via FAX at _____

I give authorization to the doctors and staff of UrbanCare, LLC to discuss any of my medical and/or financial information with the following people:

Name	Relationship	Phone
(1)_____	_____	_____
(2)_____	_____	_____
(3)_____	_____	_____

I understand that the Notice of Privacy Practices is available on the website www.urbancaredocs.com and at my physician's office. I acknowledge receipt of UrbanCare, LLC privacy policy. A paper copy is available upon request. In addition, I authorize UrbanCare, LLC to register me in I-Care (Illinois Comprehensive Automated Immunization Registry Exchange). I acknowledge that Urbancare will send my immunizations to the Illinois Comprehensive Automated Immunization Registry Exchange unless I opt out (see Receptionist for Opt Out Form).

This request may be changed or revoked by filing a new request or revoking this one in writing.

Patient name (printed): _____ Date of birth: _____

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient _____