

You may request to receive confidential communications of Protected Health Information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it. You may also request to "Opt Out" of any communications relative to fundraising activities.

We may not ask you the reason for your request. We will accommodate all reasonable requests. If you make a special request, you must give us an alternative address or other method of contacting you (phone number, email address, etc.). This restriction is FOR THIS VISIT ONLY and will automatically terminate when you are discharged from the hospital, after your outpatient visit or after your course of care is finished. I understand this restriction applies only to Torrance Memorial. Torrance Memorial does not control the release of patient information from MD offices. I understand I will need to contact my physician's office directly to make any nondisclosure requests.

Please specify how or where you wish to be contacted:

Do not send any mailing (including my bill) to my home address. Use this address instead:

Alternative Address:
City, State, Zip

Do not call me at my home phone number. Use this phone number instead:

Alternative Phone Number:

I wish to "Opt Out" from receiving any communications relative to fundraising activities.


Signature of Patient or Representative:	
Print Patient Name or Representative:	
If Representative, give relationship:	Date:

Torrance Memorial Medical Center Acceptance of Restriction:

Torrance Memorial Medical Center Representative Signature:
Date:

This restriction may be terminated if I orally agree to the termination and the oral agreement is documented by my nurse.

To be used after admission:		
<input type="checkbox"/> Restriction terminated	Date:	Time:
Patient Signature:	Staff Signature:	

 <p>REQUEST FOR RESTRICTION ON THE Manner of Confidential Communication HIPAA FORM #5 Page 1 of 1</p>	Patient Label
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