UCLA School of Dentistry
Dental Clinics

UCLA DENTAL CLINICS
REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

Patient Name:_____ Date of Birth:_____

I am requesting to receive confidential communications containing protected health information about the patient named above by the means indicated below:

☐ In writing (mailing address):_____

_____

☐ By telephone at:_____

☐ By email at:_____

_____
Patient Signature

_____ _____
Patient Name Date

OR

_____ _____
Patient's Representative Signature Relationship

_____ _____
Patient's Representative Name Date

When you have completed this form, please return it to:

Dr. Jeffrey Goldstein
General Clinic Director
UCLA School of Dentistry

Box 951668
10-136 Center for the Health Sciences
Los Angeles, CA 90095-1668