UCLA Dentistry

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. Sean Mong
General Clinic Director
UCLA School of Dentistry
Box 951668
10-136 Center for the
Health Sciences Los
Angeles, CA 90095-1668