

**REQUEST TO REVOKE A
CONFIDENTIAL COMMUNICATION
REQUEST**



You have the right to revoke a request for Confidential Communications that has been agreed to by AKDHC or PKDHC. By completing this form you are documenting that you would like to revoke a current confidential communication directive that is in place.

Please complete the below information (any section that is left blank may delay our response to your request)

PATIENT INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Date of Birth	Phone		

I request that AKDHC/PKDHC *stop* contacting me at the alternative address and phone I provided. The contact information I provided at time of registration can be used for any communications.

Patient or Legal Representative **Printed Name**

Patient or Legal Representative **Signature**

Date

If the above signature is the patient's Legal Representative complete the following:

LEGAL REPRESENTATIVE INFORMATION			
Last Name	First Name		M.I.
Address	City	State	Zip
Representative capacity (e.g. power of attorney, legal guardian, executor of estate):	Phone		

Submitting a Revocation Request Form

All requests for the revocation of Confidential Communication requests should be documented in writing and directed to the AKDHC/PKDHC Privacy Officer. Completed request forms should be mailed to the Privacy Office using the contact information below or handed to the office staff who will direct the request to the Privacy Office for you.

AKDHC Administration Attn: Privacy Officer
3333 East Camelback RD Suite 180
Phoenix, AZ 85018

Phone: 602-997-0484

OFFICE USE ONLY:			
Request Received By:		Date:	