

# CONFIDENTIAL COMMUNICATION REQUEST FORM



*This form is used when an individual requests that we use alternative means or an alternative location when communicating about protected health information.*

## **Individual Requesting Confidential Communication**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### **Please read the following and complete the information requested:**

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location. You will need to provide reasonable alternative means or location for communicating with you, and provide an explanation how any applicable payments will be handled under the alternative means or location you request. We will not investigate the validity of your request.

Please describe the protected health information you want to make subject to confidential communication:

\_\_\_\_\_  
\_\_\_\_\_

I request that you communicate with me about my protected health information by the following alternative means. Please provide full information on the alternative means you want us to use:

\_\_\_\_\_  
\_\_\_\_\_

I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location:

\_\_\_\_\_  
\_\_\_\_\_

### **INDIVIDUAL'S SIGNATURE**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*(If signature by a personal representative of the member, please complete the following)*

Personal representative's name: \_\_\_\_\_

Relationship to member:  Parent  Legal guardian\*  Holder of Power of Attorney\*

***\*Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney***