HIPAA Request for Confidential Alternative Communication of Protected Health Information

Purpose: This form is used to request that the named company provide communication(s) of Protected Health Information (PHI) in an alternate method or manner. You may make this request at any time by giving written notice to the Privacy Contact listed on our Notice of Privacy Practices. You may only request a confidential or alternative manner or method of PHI communication for yourself or if you are the personal representative of a patient.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Medical Record #: _____

***If being requested by a Personal Representative (parent, guardian, power of attorney)*

Representative's Name: _____ Relationship to Patient: _____

2. REQUEST

I hereby request to receive confidential or alternative communication(s) from the named company regarding my health condition; care, treatment, services, and/or payment by an alternative manner (check all that apply):

☐ At a telephone number other than the primary number in my record: _____

☐ At a mailing address other than my home mailing address.

Preferred mailing address: _____

_____

_____

☐ Other. Please specify: _____

3. SIGNATURE

I understand that if the named company agrees to provide me with confidential communications regarding my health care via the above alternative manner and method, the named company may condition this agreement upon the following:

a. The receipt of information from me as to how payment for named company services will be handled.
b. The specification of an alternative address or other method of contact.

Signature: _____ Date: _____

HIPAA Revocation of Request for Confidential Alternative Communication of Protected Health Information

Purpose: This form is used to revoke or to confirm revocation of a previous Request for Confidential or Alternative Communication of PHI. You may make this revocation at any time by giving written notice to the Privacy Contact listed on our Notice of Privacy Practices. You may only revoke a Request for Confidential or Alternative Communication of PHI you made for yourself or when serving as the patient's personal representative. This revocation will not affect any action we took in reliance on an initial Request for Confidential or Alternative Communication of PHI prior to receiving this revocation notice.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Medical Record #: _____

***If being requested by a Personal Representative (parent, guardian, power of attorney)*

Representative's Name: _____ Relationship to Patient: _____

2. STATEMENT OF REVOCATION

I revoke my Request for Confidential or Alternative Communication for the use and/or disclosure of my protected health information.

I understand that this revocation will not affect any action the named company or others took in reliance on my previous Request for Confidential or Alternative Communication of PHI and before receipt of this written revocation.

Date of the Request for Restriction (if known): _____ / _____ / _____

Specific description of the request for restriction to be revoked (ex: Fax all reports to my personal fax number xxx-xxx-xxxx):

_____

_____

3. SIGNATURE

To be valid, this Revocation of Request for Confidential or Alternative Communication must be signed and dated by the person listed in Section 1.

I, _____, have had full opportunity to read and consider the contents of this Revocation of Request for Confidential or Alternative Communication.

Signature: _____ Date: _____