

Request for Alternate Methods of Communications

{Covered Entity} considers your health information confidential. You have the right to request we communicate with you by an alternative delivery method (e.g. mail, phone, or email) or at alternative location (e.g. address or phone number).

{Covered Entity} will review all requests and accept those we are able to reasonably accommodate. We will not ask for a reason, but may ask how payments will be handled. Your request will be in effect until you change or rescind it by submitting a new request through another use of this form.

Name: _____ Request Date: _____

Address: _____

Phone Number: _____ Email Address: _____

This is a: New Request Change to Prior Request Withdrawal of Prior Request

I request that {Covered Entity} accommodate the follow request for confidential communications (choose preferred delivery method and address or phone number):

Information for confidential treatment: _____

Address: _____

Email Address: _____

Send by encrypted emails to assure secure transfers

Send by unencrypted email (if option chosen and accepted by {Covered Entity}, the individual must take full responsibility all confidential information that could be potentially breached. This form must be filled for each disclosure of PHI for the individual)

Telephone: _____

Other: _____

If your request is granted, this request will apply only to the communication you designated above.

Signature of Client or Legal Representative: _____

Date: _____ Relationship to Client: _____

For {Covered Entity} Use Only

Received and reviewed by: _____ Date: _____

Request has been: Accepted Denied

Reason for denial: _____

If denied, has the client been informed of denial and reasons for it? Yes No