Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Birthdate: _____ Social Security #: _____ MR #: _____

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 a reasonable alternative means or location for communicating with you and provide an explanation of how any applicable payments will be handled under the alternative means or location you request. We will not investigate the validity of your request and, as long as your request is reasonable, we can usually accommodate it.

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

_____

_____

Please explain how any applicable payments will be handled: _____

_____

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

_____

Signature: _____ Date: _____
(if signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: _____
Relationship to Patient: ☐Parent ☐Legal Guardian* ☐Holder of a Medical Power of Attorney*

* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

NOTE: Contact Case Management for inpatients already admitted to a bed who request confidential communication

EVERGREEN HEALTHCARE

REQUEST FOR CONFIDENTIAL COMMUNICATION

FORM ID ADM 541
Rev: 03/06

APPLY PATIENT LABEL HERE

Original – Medical Record Copy – Patient
Second Copy – Privacy Officer