REQUEST for CONFIDENTIAL HANDLING of PROTECTED HEALTH INFORMATION (PHI)

Please print all requested information to prevent delays & provide completed form to your facility.

Patient Name:_____
Last **First** **MI** **Maiden or Other Name**

Address:_____ **City:** _____**ST:** _____**Zip:**_____

Date of Birth:_____-_____-_____ **Phone #:**_____

I request confidential handling of communications to me regarding my PHI:

- ❑ For all health information
- ❑ Only for health information related to a particular illness or injury_____
- ❑ For a specified time period: From _____ to _____
- ❑ For billing matters only.

Communication of PHI to me should be handled in the following way:

- ❑ Mail to an alternative address of:_____
- ❑ Via Email only:_____

*For security of your records, all emails are routinely sent encrypted.

Unencrypted email disclaimer:

I understand that records sent through unencrypted email poses a security risk but it is my requested method of receipt._____(Please initial)

- ❑ To an alternative telephone number:_____
- ❑ Other (please specify):_____

I understand that you have the right to deny my request if it would be difficult to administer. I agree that if this request impacts how payment is made for health care services provided to me, I will guarantee payment of these services by paying in full at the time of the request.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

_____
RELATIONSHIP TO PATIENT

FOR INTERNAL USE ONLY

Complete the section below and retain with patient file.

Decision

Confidential Handling: ❑ Completed ❑ Denied

If denied, reason for denial is:
- ❑ We are unable to administer the request
- ❑ Other_____

_____ _____
Name of associate that processed request Date Request was processed