



## Request for Alternate Confidential Communications

Patient Name: \_\_\_\_\_ Med Rec / Account # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Use this form to make a request to Provider for Confidential Communications. This is a request to receive communications of protected health information by alternative means or at alternative locations (e.g. an address other than the subscribers). This request may be denied if the member is not in danger. It may also be denied if it cannot reasonably be accommodated.

☐ I request to receive communications of protected health information from Provider by alternative means or at alternative locations.

Please describe your request: \_\_\_\_\_  
\_\_\_\_\_

Please provide the reason why the alternate means or location is necessary: \_\_\_\_\_  
\_\_\_\_\_

☐ In addition, I request that provider restrict disclosures of my protected health information to the following family member (print name and the family member's relationship to you) \_\_\_\_\_.

If approved, the family member listed in this section will not be able to access your protected health information over the phone and in some circumstances no other family members will be able to access your protected health information over the phone.

### New Communication/Contact Information:

Check the box for the communication channel you wish to change. Enter the new information on the corresponding lines.

- ☐ Street Address: \_\_\_\_\_  
☐ City, State, Zip: \_\_\_\_\_  
☐ Telephone/Fax #: \_\_\_\_\_  
☐ Email Address: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

Please read the following:

- I understand that this request may be denied if it cannot reasonably be accommodated.
- If your request is granted, it will affect only communications from Provider. If you also wish you employer, group health plan, physician or anyone other than Provider to make this change, you must obtain their agreement separately.
- If the information on this form is not complete, Provider will return the form, and this request will not be considered until completed information is received.
- If your request is granted, it will remain in effect until you change or revoke it.
- You may change or revoke this request by completing a Change/Revoke form.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ (when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).

Signature of Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Legal Representative: \_\_\_\_\_

Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney (attach documentation)

☐ Other \_\_\_\_\_ (Explain and Attach Documentation)

---

### For Internal Use Only

Please return this completed form to the Corporate Compliance Department, 607 Dewey Ave. NW, Suite 300. Grand Rapids, MI 49504.

Information Released/Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Office: \_\_\_\_\_ Request Granted ☐ YES ☐ NO

### Change / Revoke Request

This form allows patients to request a change or revocation to a previously approved request for an Alternate means of Confidential Communication.

RESTRICTION REVOCATION/CHANGE: Please complete this section ONLY if you have an active privacy restriction on file with Provider and you wish to revoke or change the restriction.

- ☐ I wish to revoke my restriction to deny family members access to my PHI via phone.
- ☐ I wish to revoke all other restrictions. Please describe the specific restriction request you wish to revoke:

---

---

---