# [NAME OF PRACTICE]

## REQUEST FOR CONFIDENTIAL COMMUNICATIONS INVOLVING PROTECTED HEALTH INFORMATION

You have a right to request that [Name of Practice] ("Covered Entity") provide alternative means or alternative locations for you to receive communications of protected health information. We must agree to your request for a confidential communication **only** if (1) you provide a reasonable alternative means or locations for the communication, and (2) you believe that a disclosure of the information could endanger you.

Please submit this form to: [Name of Privacy Official], Privacy Official
[Name of Practice]
[Address of Practice]

**Your Name** _____

**Address** _____

**Daytime telephone number** _____

**Please select one:**

_____ I am a patient of Covered Entity.

_____ I am the personal representative of a patient of Covered Entity (*please attach proof of personal representative status*).

My request for confidential communications from Covered Entity applies to the following types of communications (list):

(If more space is needed, please attached a separate sheet)

The communications identified above should be made to me in the following manner (please provide an alternative address, telephone number, or e-mail address):

**Please Read Carefully and Sign**

I believe that disclosure of my protected health information in the communications described above could endanger me. I understand that Covered Entity is not required to agree to my request for a confidential communication if I do not provide a reasonable alternative means for the communications or if I do not believe that the disclosure of information in the communication will endanger me.

_____ _____

By: Date