

### Patient Request for Confidential Communications

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

Telephone # most easily reached: \_\_\_\_\_

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

I request that AdvantageCare Physicians accommodate the following request for confidential communications (check preferred delivery method and address or phone number):

Information for which confidential treatment is requested: \_\_\_\_\_

Delivery Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Other (Specify): \_\_\_\_\_

By signing this authorization form to request confidential communications from AdvantageCare Physicians about my medical information, I understand that:

- I may request to receive communications about my protected health information by alternative means or at an alternative location.
- If my request is granted, this request will apply only to the information I have designated above and communication type (address, telephone, other).
- AdvantageCare Physicians will accommodate all reasonable requests and if the request is accepted, AdvantageCare Physicians will communicate with me in the manner consistent with this request.
- If AdvantageCare Physicians cannot accommodate my request, I will be notified of the denial and the reasons why.
- I have the right to revoke or modify this request at any time. The request must be made in writing and presented to the applicable AdvantageCare Physician medical office or mailed to the Director of Health Information Management at the following address: 55 Water St., 12<sup>th</sup> Floor Rm 12G09, New York, NY 10041.
- Unless otherwise revoked or modified, this restriction will expire on the following date/event/condition: \_\_\_\_\_ . If I fail to specify an expiration date/event/condition, this authorization will expire 6 months from the date signed.
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- Under emergency situations, AdvantageCare Physicians will first attempt to communicate with me as requested above. If unable to contact me, AdvantageCare Physicians will attempt to reach me by other means.
- I understand that signing this request is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this request.
- Completed forms may be:
  1. Dropped off at an AdvantageCare Physicians medical office site with Attention to: Practice Administrator or
  2. Mailed to:  
Privacy Officer  
AdvantageCare Physicians  
55 Water Street, 12<sup>th</sup> Floor, Rm 12H92  
New York, NY 10041

\_\_\_\_\_  
Signature Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Authorized Representative

\_\_\_\_\_  
Relationship to Patient or Authority of Authorized Representative

### For ACP Use Only

Date Received: (MO/DY/YR) \_\_\_/\_\_\_/\_\_\_\_

- Received by (print): \_\_\_\_\_
- Scanned to HIM by Medical Office

Disposition of Request: \_\_\_ GRANTED \_\_\_ DENIED (Notify Requestor)

Reason for Denial: \_\_\_\_\_

If request denied, Requestor notified (MO/DY/YR) \_\_\_/\_\_\_/\_\_\_\_