

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: (Last) _____ (First) _____ (M.I.) _____

Address: (Street/Box) _____ (City) _____ (State) _____ (Zip) _____

Telephone: (day) (____) _____ (eve) (____) _____

Medical Record #: _____ (Optional) Date Of Birth _____

Information about your rights to receive confidential communications of your health information:

- ◆ You have the right to request and receive communications of your health information from the Organization by an alternative means or at an alternative address.
- ◆ If you make a special request, you must give us the alternative address or other method of contacting you.

Provide an alternative address or an alternative method (alternative phone number, fax number, etc.) of contacting you:

By submitting this form, I request Saint Joseph Mercy Health System to communicate with me by the alternative means or at the alternative locations specified above. This request, if agreed to, is effective on the date the agreement is made and expires on _____ [indicate date]. I understand that the Organization will accommodate my request, as set forth above, if the Organization determines that my request is reasonable.

Signature of Patient or Representative

Date

Date form received

This form should be sent to: Saint Joseph Mercy Health System, Health Information Services, 5301 East Huron River Dr., PO Box 995, Ann Arbor, MI 48106-0995.

- Saint Joseph Mercy Health System agrees to accommodate the request as outlined above
- The following facts and circumstances have lead Saint Joseph Mercy Health System to determine that your request cannot be reasonably accommodated:
[_____

_____]

If you have any questions, please contact _____ at _____.

Name of SJMHS Representative

Date of Agreement or Denial