Request for Confidential Communication of Protected Health Information

I request communication of my protected health information from Mercy Health by alternative means or at an alternative location. I understand this request applies to communications from Mercy Health to me and, if applicable, to the named insured of an insurance policy that covers me as a dependent of the named insured.

Patient/Patient Representative Signature _____ Date _____

Authority to sign if not the Patient _____

Printed Name _____

Patient Date of Birth _____ Last 4 digits of Patient SSN: _____

☐ I would like this request to remain in effect for this visit and all future visits until I notify Mercy in writing requesting a change.

☐ I would like this request to remain in effect for this visit only.

Please indicate the methods and/or locations where we may contact you or provide you other written communication.

Telephone Number _____

Mailing Address _____

Other Contact Information _____

Additional Instructions _____

_____

_____

Co-worker Accepting Request (Print) _____ Title _____ Date/Time _____