Mercy

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:_____

Mercy Health Location for Confidential Communication:_____

_____

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 _____

_____

_____

NOTE: This request will remain in effect until you notify Mercy in writing requesting a change.

_____ _____ _____

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