AdvantageCare PHYSICIANS

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., 12th 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, 12th 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) ___/____/____