Request for Confidential Handling of Protected Health Information (PHI)

Please print all requested information to prevent delays & provide completed form to your facility

Patient Name: _____
               Last   **First**   **MI**   **Maiden or Other Name**

Address: _____ **City:**_____ **ST:**_____ **Zip:**_____

Date of Birth:_____-_____-_____   **Phone #:**_____

I request confidential handling of communications to me regarding my PHI:

❑ For all health information

❑ Only for health information related to a particular illness or injury _____

❑ For a specified time period: From _____T o _____

❑ For billing matters only.

Communication of PHI to me should be handled in the following way:

❑ Mail to an alternative address of:_____

❑ Via Email* only: _____

*For security of your records, all emails are routinely sent encrypted.

Unencrypted email disclaimer:
I understand that records sent through unencrypted email poses a security risk but it is my requested method of receipt._____(Please initial)

❑ To an alternative telephone number:_____

❑ Other (please specify): _____

I understand that you have the right to deny my request if it would be difficult to administer. I agree that if this request impacts how payment is made for health care services provided to me, I will guarantee payment of these services by paying in full at the time of the request.

_____   _____
SIGNATURE OF PATIENT   **DATE**

OR

_____   _____
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON   **DATE**

_____   _____
RELATIONSHIP TO PATIENT   **DATE**

Partners in Integrated Care. Cardiology   CAC FLORIDA Medical Centers   Continucare Medical Centers   MetCare   Partners in Primary Care.

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FOR INTERNAL USE ONLY
Complete the section below and retain with patient file.

Notice of Decision

Confidential Handling: ❑ Completed   ❑ Denied

If denied, reason for   ❑   We are unable to administer the request
denial is: ❑   Other_____

_____   _____
Name of associate that processed request   Date Request was processed