THE UNIVERSITY OF ARIZONA

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

I, _____, request communication of my Protected Health Information (PHI) by UA by alternative means or at alternative locations. I understand this request applies only to communications from this clinic or department to the patient and communications that would be sent to the named insured of an insurance policy that covers the patient as a dependent of the named insured.

Please indicate the methods and/or locations by or at which we may contact you.

☐ Telephone: (_____) _____

☐ Mailing Address: _____

_____

☐ Other: _____

Description of communication(s) to be restricted:

_____

_____

NOTE: This request will remain in effect until you notify us of a change.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

Patient's Date of Birth: _____

Original: Medical Record
Copy: Billing Record

HPP Use Only:
HIPAA Privacy Program
v. 2015