GlobalHealth

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION ("PHI")

NOTICE: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") allows you to request alternate means of communicating your confidential Protected Health Information ("PHI"). We are not required to honor all requests. Please use this form to describe the particular method of communication you are requesting. If we agree to your request for confidential communication of your PHI, it will be effective on the date this form is signed, but will not apply to any uses or disclosures we have made prior to this date.

Name: _____ Date of Birth: _____

Member ID #: _____ Phone Number: _____

Address: _____

Please describe in detail what you are requesting. Tell us the address, phone number, or email you DO NOT wish to be contacted, and how it differs from the information we have on file.

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Understanding and Acknowledgement

I acknowledge that my request may be refused for reasons permitted under HIPAA. If making this request for someone other than myself, I certify I am the individual's legally authorized personal representative and am requesting this limitation or restriction in good faith and in the best interest of the affected individual. I understand GlobalHealth may require documentation establishing legal authority of personal representative for the above named patient, including but not limited to, a durable power of attorney for health care.

_____ _____

Signature of Person Submitting Request Date

_____ _____

Printed Name Relationship to Patient/Member

For Facility Use Only:

Date Received: _____ _____ Accepted _____ Denied

_____ _____

GlobalHealth Representative Date

MRCCPHI 03/2013