MetroHealth

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____

Date of Birth: _____ Medical Record Number: _____

Address: _____

Phone Number: _____

I am requesting confidential communications for the encounter below. I am requesting that The MetroHealth System (MHS) send communication for this encounter by a different method (such as email or telephone) or to a different location (such as an address other than home address). I understand that MHS may accept or deny my request. This request will be effective indefinitely unless otherwise indicated.

Dates of Specific Health Information: _____

Specific Conditions to be Restricted: _____

Alternate Means or Location: _____

Patient Signature: _____ Date: _____

Name of Personal Representative (if applicable): _____

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____

Forward completed form by email to HIPAAprivacy@metrohealth.org, fax to (216) 778-8777 or mail to The MetroHealth System, Attn: Privacy, 2500 Metrohealth Drive, Cleveland, OH 44109

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For MHS use only:

Date Request Reviewed: _____

Position Titles of Reviewers: _____

Request is: ☐Approved ☐Denied Reason for Denial: _____

Final Action Taken: _____

Flagged in electronic record: ☐ Completed

Privacy Officer's/Designee's Signature: _____ Date: _____