

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_ MR #: \_\_\_\_\_

**Please read the following and complete the information requested**

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location. You will need to provide a reasonable alternative means or location for communicating with you and provide an explanation of how any applicable payments will be handled under the alternative means or location you request. We will not investigate the validity of your request and, as long as your request is reasonable, we can usually accommodate it.

Please describe the protected health information you want to make subject to confidential communication:

\_\_\_\_\_  
\_\_\_\_\_

Please explain how any applicable payments will be handled: \_\_\_\_\_

\_\_\_\_\_

I request that you communicate with me about my protected health information by the following alternative means or at the following alternative location. (Please provide full information on the alternative means or location you want us to use): \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(if signed by a personal representative of the patient, please complete the following)

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient:  Parent  Legal Guardian\*  Holder of a Medical Power of Attorney\*

\* Please attach Legal Documentation if you are the Legal Guardian or Holder of Power of Attorney

**NOTE:** Contact Case Management for inpatients already admitted to a bed who request confidential communication

 **EvergreenHealth** Kirkland, WA 98034

**REQUEST FOR  
CONFIDENTIAL COMMUNICATION**

FORM ID ADM 541

Rev: 03/06

APPLY PATIENT LABEL HERE

Original – Medical Record      Copy – Patient  
Second Copy – Privacy Officer