SOUTHEAST MISSOURI STATE UNIVERSITY

Please check the appropriate Health Care Component

❒Self-funded Health Plan ❒Health Clinic ❒Autism Center

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, _____, hereby request that all communications of protected health information related to _____ be made to me [initial all that apply]:

_____ by the following means (i.e., e-mail, regular mail, alternative phone number, etc.) [please include all information necessary to comply with your request]: _____

_____

_____

_____

_____ at the following address: _____

_____

_____

_____ _____

Dated Signature of Patient or Patient's Representative

_____

Description of Representative's Authority

_____

FOR OFFICE USE ONLY

Received: _____

_____ The Covered Entity will accommodate this request.

_____ The Covered Entity will not accommodate this request because it is deemed to be unreasonable for the following reasons: _____

_____

_____

_____

_____

Signature