

REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS

I hereby request that my Protected Health Information including clinical information (e.g., test results, patient instructions), billing information, and other facility communications (e.g., patient surveys) be communicated to me via the alternate address/phone number listed below.

I understand that this request for Confidential Communications will apply to all future communications related to the date of service listed below unless I request a change in writing.

NOTE: This request only applies to communications from this health system. If you wish to request Confidential Communications from your physician's office or your insurance company, you must contact them directly.

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected/out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, the facility will communicate with me via other means and/or at other locations.

This request is for the date of service/treatment of: _____.

ALTERNATE ADDRESS/PHONE NUMBER:

NOTE: Only U.S. addresses and phone numbers will be accepted. All information requested below must be completed in order for this request to be processed by the facility.

Patient Name: _____

Street Address: _____

Suite/Apt. Number (if applicable): _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

OTHER REQUESTS (e.g., alternate means): All other requests must be referred to the Privacy Officer and or designee at Privacy@med.usc.edu.