Request for Confidential Communications

This form is used for an Individual to request confidential communications. Individuals have the right to request that communications from HealthTrust be delivered by alternative means or at alternative locations (such as postal address, email address, telephone number). (45 CFR § 164.522 (b)).

I request to that communications from HealthTrust be delivered by alternative means or at alternative locations. (Please complete one (1) through three (3) below. If not applicable, mark N/A in the box. Please use the back of this form if additional space is required).

1	I request all postal mail communications be sent to (enter address):
2	I request all electronic communications be sent to (enter email):
3	I request all phone calls be made to (enter phone number):

☐ Please check this box if disclosure of all or part of the information to which this request pertains could endanger you.

Your Name (printed):	Your Contact Information (Address, Phone, Email):
Your Signature:	Date:

If a legal representative signs on behalf of the individual, a copy of the legal representative's authority must be attached to this form, e.g. Health Care Power of Attorney, Executor/Administrator of an estate.

TO BE COMPLETED BY HEALTHTRUST WORKFORCE MEMBER Reference: HIPAA Individual Rights Policy.	
Name of HealthTrust Workforce Member Receiving Form:	Date: