6416 Old Winter Garden Rd.
Orlando, FL 32835
PH: 866-222-0403

Request for Confidential Handling of Protected Health Information

I, _____ Date of Birth _____
request an alternative means of communication of my health information (e.g., mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by the organization and disclosure by alternative means may not be protected and could endanger me. I understand that request for FAX communication may be intercepted by others and the organization is not responsible if such intercepts occur.

Please describe the protected health information that requires alternative means or alternate location communications:

_____

_____

Please describe in detail your proposed alternative means or alternate location for receiving communications from the organization:

_____

_____

☐ **Alternative Mailing Address:**

_____
Street No.

_____
City State Zip code

☐ **Alternative Means of Contact (Please Specify):**

_____

( ) -
Alternative Phone Number:

Unless otherwise revoked, this authorization will expire **12 months** following the date of signature.
I acknowledge that I have read this form or it has been read to me and I understand its content.

Signature _____ **Date** _____

Relationship to Patient:
If signed by a person other than yourself, please check the relationship and provide proof of authority.

☐ Self ☐ Legal Representative* ☐ Parent of Minor Child ☐ Other (specify)

_____ _____
****Name of Interpreter/Translator (If Required)** **Telephone**

***If signed by a person other than yourself, please check the relationship and provide proof of authority to do so.**

****If a translator or interpreter was required.**

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FOR OFFICE USE ONLY

Request is: ☐ Approved ☐ Denied

Check reason for denial:
☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided
☐ Failure to provide information on how payment will be made (if applicable)
☐ Other (please explain)

Associate's Name: (Print)	Title
Associate's Signature	Date Completed