ELY AREA AMBULANCE SERVICE
Patient Request for Confidential Communications
of Protected Health Information

Patient Name: _____Phone:_____

Street Address: _____

City: _____State: _____ Zip Code: _____

Email: _____Date of Birth: _____

Right to Request Confidential Communications of Your PHI and Our Duties:

You (or your authorized representative) have the right to request that we send your PHI to an alternate location (*e.g.,* somewhere other than your home address), or in a specific manner (*e.g.,* by email rather than regular mail). We will only comply with reasonable requests when required by law to do so. We will notify you about our decision regarding your request by phone or email. Please provide us with appropriate contact information.

Requested Confidential Communications:

Below, please describe the manner in which you would like us to communicate PHI to you and specify what PHI you would like us to communicate in that manner. Specify dates that this request would apply during, and other details that will allow ELY AREA AMBULANCE SERVICE to accurately and completely fulfill your request.

_____

_____

_____

Signature of Requestor: _____ ***Request Date:*** _____

Contact Information to Notify You About Our Decision Regarding Your Request:

Phone: _____Email_____

Requestor Information (if requestor is different from patient):

Name: _____

Relationship to Patient (parent, legal guardian, etc.):_____

Street Address: _____

City: _____State: _____ Zip Code: _____