



REQUEST FOR ALTERNATIVE COMMUNICATION OF PROTECTED HEALTH INFORMATION

You may tear off this page and retain it for your records.

The attached form may be used to request a specific means or an alternative location for the organization to communicate your Protected Health Information to you. All reasonable requests for communications via specific means or at alternative locations will be granted. Specific means include, for example, e-mail and facsimile transmissions. Alternative locations include, for example, work addresses or friends' addresses.

A request not to receive any information and any request that may interfere with the ability to obtain payment for the services provided to you will be denied, unless appropriate information about how payment will be handled is provided.

EXAMPLE: You are responsible for any additional costs associated with communications via a specific means or to an alternative location. For example, if you request overnight mail delivery of laboratory test results, you will be expected to pay the postage prior to delivery.

To submit a request for communications via specific means or at alternative locations, please complete the attached form and return it to individual from St. Luke's who provided the form to you or mail it to:

HIPAA Contact Office
Health Information Services
St. Luke's Regional Medical Center
190 East Bannock
Boise, ID 83712



REQUEST FOR ALTERNATIVE COMMUNICATION OF PROTECTED HEALTH INFORMATION

Today's Date: _____

Patient's Name: _____

Medical Record Number (if known): _____

Birth Date: _____ Social Security: _____

Address: _____

Phone (Home) _____ (Work) _____

A. Affected Protected Health Information

Please restrict communication of the following information to the methods or locations listed below:

B. Alternative Means or Location

Please communicate the Protected Health Information described above ONLY to the following location:

___ Please communicate the Protected Health Information described above ONLY via the following means:

___ E-mail Address: _____

___ Fax Number: _____

___ Regular U.S. Mail Address: _____

___ Overnight Mail Address: _____

___ Other: _____

C. Costs

The costs associated with the above request will be paid for, in advance, via the following method:

If you are not the patient, please fill in the following:

Your Name: _____

Your Relationship to the Patient: _____

Your Address (if different than above): _____

Your Phone (if different than above) (Home) _____ (Work) _____

Signature: _____

Date: _____