Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH

PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION

Patient Rights-P
HIPAA Privacy Patient Rights

IDN13150017

INSTRUCTIONS: You have the right to request how we communicate about all or part of your protected health information by alternative means or to an alternative location. (Note: This request is limited to the department in which you make the request).

Patient Information – please provide us with the following information about the patient:

Last Name	First Name	Middle Name
Street Address	City	State
Zip Code	XXX-XX- _____ Last 4 SSN	Date of Birth
Patient Signature	Date of Request	Phone Number

Personal Representative – if you are the patient's personal representative, please provide your information below:

(Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers).

Last Name	First Name	Middle Name
Personal Representative Signature	Date of Request	Relationship to Patient

Send information specified below by the following alternative means or to the following alternative address or telephone number:

Department Name _____ Department Location _____

Identify the protected health information you want to make subject to confidential communication:

_____ Lab results _____ Billing

_____ Treatment information _____ Other: (please explain): _____

How do you wish for the department to communicate with you? _____ Phone _____ Postal Mail

When completed, please return this form to:

Rush University Medical Center, ATTN: Privacy Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833
Telephone: (312) 942-5303 • Fax: (312) 942-6875