Confidential Communications Request Form

Use this form to request that Trios Health and Clinics use an alternative means or an alternative location when communicating with you about your protected health information (PHI). We will accommodate your request if all of the following criteria are met:

1. Your request is reasonable;
2. You provide reasonable alternative means or location for communicating with you; and
3. You provide a satisfactory explanation how any payments (if applicable) will be handled using the alternative means or alternative location that you request.

You may also use this form to terminate a previously submitted request for confidential communications.

If you need assistance in completing this form, please call the Trios Privacy Officer at 509-586-5883.

PLACE PATIENT LABEL HERE OR HANDWRITE	
Name:	**Date of Birth:**
Address:	
	Area Code & Telephone #:
E-mail Address:	

Please indicate the PHI that you would like to have communicated by alternative means or at an alternative location:_____

_____

_____

_____

_____

I request that the PHI designated above be communicated by the alternative means or at the alternative location below (check one)

☐ Mailing address:_____

☐ E-mail address:_____

☐ Phone Number:_____ ☐ Fax Number:_____

Please indicate how any payments (if applicable) will be handled using the alternative means or alternative location that you request:_____

_____

_____

☐ Please terminate my previous request for Confidential Communications.

Signature: **Date:**

The form must be completed entirely. When complete send to:

Trios Health

Privacy Officer 900 S. Auburn St. Kennewick, WA 99336
Trios Privacy Officer Use Only:
Was the request granted? □Yes □No
If the request could not be granted, please explain:
If the request was granted, how was it communicated to all at TRIOS who will need to know?
Was the request logged in the Privacy Officer log? □Yes
When and how was the requestor notified of the decision?
Privacy Officer Signature:
Date: