

<b>DEPARTMENT:</b> Information Protection	<b>POLICY DESCRIPTION:</b> Patients' Right to Request Confidential Communications
<b>PAGE:</b> 1 of 2	<b>REPLACES POLICY DATED:</b> 4/1/03
<b>EFFECTIVE DATE:</b> March 1, 2008	<b>REFERENCE NUMBER:</b> IP.PRI.008 (formerly HIM.PRI.008)
<b>APPROVED BY:</b> Ethics and Compliance Policy Committee	

**SCOPE:** All Company-affiliated facilities including, but not limited to, hospitals, ambulatory surgery centers, imaging and oncology centers, physician practices, and shared services centers (SSC).

**PURPOSE:** To ensure patients the right to request Confidential Communications as required by the Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, and any and all other Federal regulations and interpretive guidelines promulgated thereunder.

**POLICY:**

Patients will be provided the right to request Confidential Communications by alternative means or to alternative locations. All reasonable requests for Confidential Communications must be accommodated by the facility. Confidential Communications pertain to all future correspondence and communication related to the specific visit(s) stated in the request.

Acceptable alternate means of communication include mail, telephone, and in limited circumstances may include fax and encrypted e-mail. Any requests for communication via phone only must also include a mailing address (permanent or alternate) for purposes of billing and collections. Unacceptable means include unencrypted e-mail and Internet communications (as security of the transmission cannot be guaranteed).

Acceptable alternate locations include all U.S. mailing addresses and all U.S. phone numbers. Patients requesting an alternate address must also provide their regular mailing address so that it may be maintained in their record.

**PROCEDURE:**

1. The right to request confidential communications and the process for making the request must be outlined in the Notice of Privacy Practices.
2. The patient, or patient's legal representative, shall complete and sign the "Request for Confidential Communications" form (see Attachment A). The form may be submitted to the facility or SSC at any time.
3. The employee receiving the form from the patient will review it to verify that it has been completed satisfactorily. The employee may not ask for an explanation from the individual as to why the request is being made. Once the employee has verified the form, a copy of it will be provided to the patient.
4. Depending upon where the form is received (facility or SSC), the remaining copies of it will be routed to either the facility's Patient Access/Registration department or SSC Customer Service. Once they receive the form, they will follow the standard procedure for system entry and forward

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the remaining copies as designated on the request form. Upon receipt of their copy, the Facility Privacy Official (FPO) will be responsible for notifying any additional parties that may need to take appropriate action.

5. Each facility or SSC and/or its departments shall develop a process to ensure that the appropriate patient address/phone as reflected in the system/record is used when communicating with the patient.
6. If the alternate phone number is not in service, or the correspondence sent to the alternate address is returned undeliverable, the situation should be reported to the FPO immediately. The FPO will notify the patient, via the alternate address (if the phone is disconnected) or the alternate phone (if the mail was returned undeliverable) that they must respond within seven (7) calendar days or the facility or SSC will begin communicating with them via other means and addresses as provided. The FPO will be responsible for notifying all applicable parties to take appropriate action.
7. If the individual fails to respond to communications sent to an alternate address or by alternate means within a timeframe acceptable to the facility or SSC, the situation should be reported to the FPO immediately. The FPO will notify the patient, via the original alternate means and/or alternate location, that they must respond within seven (7) calendar days or the facility or SSC will begin communicating with them via other means and addresses as provided. The FPO will be responsible for notifying all applicable parties to take appropriate action.
8. The patient must complete another "Request for Confidential Communications" form to revise the alternate means or alternate address. When the form is received by the facility or SSC, it will be processed beginning with Step 2 of this same procedure.
9. The patient must complete a "Confidential Communications Revocation" form (see Attachment B) to revoke the alternate address or alternate means. When the form is received by the facility/SSC, it will be processed beginning with Step 2 of this same procedure.
10. All forms/requests for confidential communications must be maintained for a minimum of six (6) years.

**REFERENCES:**

1. Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164
2. Patient Privacy Program Requirements Policy, [IP.PRI.001](#)
3. Notice of Privacy Practices Policy, [IP.PRI.007](#)

**(Facility Name)**  
**Confidential Communications Request**

I hereby request that my protected healthcare information including clinical information (e.g., test results, patient instructions), billing information, and other facility communications (e.g., patient surveys) be communicated to me via the alternate address/phone listed below.

I understand that this request for Confidential Communications will apply to all future communications related to the date of service listed below unless I request a change in writing.

***NOTE: This request only applies to communications from this facility. If you wish to request Confidential Communications from your physician's office or your insurance company, you must contact them directly.***

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected/out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, the facility will communicate with me via other means and/or at other locations.

This request is for the date of service/treatment of \_\_\_\_\_.

**ALTERNATE ADDRESS/PHONE:**

***NOTE: Only U.S. addresses and phone numbers will be accepted. All information requested below must be completed in order for this request to be processed by the facility.***

Patient Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Suite/Apt. Number (if applicable): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Patient/Patient Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**OTHER REQUESTS (e.g., alternate means):** All other requests must be referred to the Facility Privacy Official (FPO). The FPO may be contacted at *(insert phone number and/or office location)*.

**FACILITY USE ONLY:** Patient Med Record Number: \_\_\_\_\_ Patient Acct Number: \_\_\_\_\_

System updated to reflect alternate information by:

\_\_\_\_\_

Initials

\_\_\_\_\_

Date

Copy 1 – Patient Chart

Copy 2 – SSC FPO/Billing Office

Copy 3 – Patient

Copy 4 – Facility FPO

**\*ADMIN\***

\*ADMIN\*

I hereby revoke my request for confidential communications for the date of service/treatment of

\_\_\_\_\_.

**(Facility Name)**  
**Revocation of Confidential Communications Request**

***NOTE: This revocation only applies to communications from this facility. If you wish to revoke a request for Confidential Communications submitted to your physician's office or your insurance company, you must contact them directly.***

Patient Name: \_\_\_\_\_

Patient/Patient Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

<b>FACILITY USE ONLY:</b> Patient Med Record Number: _____ Patient Acct Number: _____	
System updated to reflect permanent information by:	
_____	_____
Initials	Date

Copy 1 – Patient Chart

Copy 2 – SSC FPO/Billing Office

Copy 3 – Patient

Copy 4 – Facility FPO

**\*ADMIN\***

\*ADMIN\*