GASTRO HEALTH

www.gastrohealth.com

CONFIDENTIAL COMMUNICATION REQUEST FORM
RESTRICTIONS ON HOW WE COMMUNICATE WITH YOU

You have the right to request that Gastro Health communicate with you by alternative means or at an alternative location if the disclosure of your Protected Health Information could endanger you. Please use this form to initiate a request of this nature. You may also use this form to request a restriction to your use or disclosure of Protected Health Information for payment and health care operations purposes.

We will accommodate your request if all of the following criteria are met:

1. Your request is reasonable;
2. You clearly state that failure to honor your request could endanger you;
3. You provide reasonable alternative means or location for communicating with you, and;
4. You provide a satisfactory explanation of how your invoices (if applicable) will be handled if the alternative location is used.

PLEASE NOTE: DO NOT USE THIS FORM TO SIMPLY CHANGE YOUR ADDRESS.
If you need assistance in completing this form, or with a change of address, please call the Privacy Officer at (305) 913-0682.

You may also use this form to terminate or modify a previously granted request for confidential communications.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:

Gastro Health
Attn: Privacy Officer
9500 S. Dadeland Blvd., Suite 200
Miami, FL 33156

Section A: Confidential Communication Request or Modification/Termination of Previous Request

Please choose one of the following:

☐ **Initial Request** – This form is an initial Confidential Communication Request. (Complete entire form.)
☐ **Modify a previous Request** – This form is modifying (i.e., changing the alternative address) a previously approved Confidential Communication Request. (Complete entire form.)

☐ **Terminate a previous Request** – This form is terminating a previously approved Confidential Communication Request. (Complete Section B and proceed to Section D.)	Enter date to terminate previous request: **Date: month/day/year**

Section B: Please complete the following about your information:

Name	**Social Security Number**	**Date of Birth**
Address	**City, State, ZIP**	
Telephone Number	**E-mail address (optional)**	

Section C: Please complete the following about the confidential communication request:

Will the failure to communicate your PHI through an alternative location endanger you? If you select "no", please call the customer service number on the back of your identification card to request an address change.	☐ **Yes**	☐ **No**
Please indicate if this restriction request should apply to communicating your PHI to your Health Savings Account (HSA) or Flexible Savings Account (FSA), if applicable:	☐ **Yes**	☐ **No**

Section C (cont): Please complete the following about the confidential communication request:

I request that all of my PHI be communicated at the alternative location listed below:

Alternative Location: Street Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

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

_____

_____

_____

If this request is granted, please note the following:

1. **This request will expire eighteen (18) months from the date placed on the signature line.**
2. **Gastro Health and its Business Associates are only responsible for the PHI that they release to the alternative address you have designated in Section C.**

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Gastro Health release my PHI as specified in Section C above. I understand that Gastro Health is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: month/day/year**

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Gastro Health.

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____

Personal Representative's Address **City, State, ZIP**

_____ _____

Personal Representative's Telephone Number **Personal Representative's E-mail address (optional)**