

DOCTORS OF WOMEN

Requests for Confidential Communication of Protected Health Information

Name:	
Address:	
City, State, and Zip:	
Telephone number:	
Date:	

I, _____, request that *DOCTORS OF WOMEN* provide communications regarding my protected health information to the following:

	Alternative method of contact
	Alternative Location

I understand that I will be responsible for any additional costs associated with this request to provide my protected health information at the alternative location or by alternative means.

For Health Plans only:

I understand that disclosure of all or part of the requested information may endanger me.

Individual's Signature

Date