

**Polk County Board of County Commissioners
Request for Confidential Communications
of Protected Health Information**

You have a right to request to receive communications of protected health information (PHI) by alternative means or at alternative locations. Please complete the following information so that we may assist you:

Print Patient's Full Name: _____

SSN or Other Patient Identifier: _____

I would like to receive communications of PHI as follows:

Phone: _____

Address: _____

Additional Comments/Requests: _____

Could the disclosure of all or part of the PHI endanger the patient? ' Yes ' No

Desired Effective Date: _____

Polk County must accommodate reasonable requests by patients to receive communications of PHI from Polk County by alternative means or at alternative locations.

If you have any questions, please contact Polk County's Privacy Officer at _____.

Signature of Patient or
Personal Representative: _____

Date Signed: _____

<p><i>For internal use only:</i></p> <p>Date Received: _____</p> <p>Recipient: _____</p>
