Jefferson County Department of Health

Request for Alternative Confidential Communications

Patient Information

Last Name	First name	Middle Name	Date of Birth
Address		Telephone Number	
Medical Record Number (if known)		Date of Request	

I hereby request that my protected health information including clinical information (i.e., test results, patient instructions), billing information and other facility communications (i.e., surveys) be communicated to me via the alternate address/phone number listed below. I understand this request for confidential communications will apply to all future communications related to the date(s) of service listed below unless I request a change in writing. I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected or out of service, or if I fail to respond in a timely manner to communications via an alternate address/phone that I have provided, JCDH will communicate with me via other means and/or at other locations.

This request is for services received in _____(clinic or program) at _____(location) on _____(date of visit). This request is for _____this one visit _____all future visits to this program area.

Alternate Address/Phone

Name:_____

Street Address:_____Suite/Apt. Number (if applicable): _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Revocation

This revocation applies to communications described above.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Office Use (JCDH staff fax form to (205) 930-1305 or deliver to ROI Division)

Request Received By:_____(signature) Dept:_____Date:_____

☐ Request scanned into EMR _____Date: _____
Send original to ROI Division

☐ System(s) updated to reflect alternate information _____Date: _____

Original on File in ROI Division
JCDH-CSD-1230-12/2023