ATTACHMENT A

REQUEST TO RECEIVE CONFIDENTIAL INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS

I, _____, request that I receive my Protected Health Information by alternative means or at an alternative location. I understand this request applies only to communications between LSUHSC-NO and me.

PLEASE USE THE FOLLOWING TO CONTACT ME:

Mailing Address _____
_____
_____

Telephone Number _____

Other _____

THIS REQUEST WILL REMAIN IN EFFECT UNTIL YOU NOTIFY US OTHERWISE.

_____

Signature of Patient or Personal Representative: Date:

_____

Printed Name of Patient or Personal Representative

_____

Documentation of Personal Representative's Authority

Date of Birth_____ Patient's SSN #_____

Original: Patient's Medical Record
Copies: Facility or Clinic Billing Record, Privacy Officer