Yale Medicine | Yale NewHaven Health

## Request for Confidential Communications of Protected Health Information (PHI)

Confidential communications afford patients the ability to request a different mailing address, phone or email address be used for communication. By completing this form, you are requesting that your protected health information, including clinical information (*e.g.*, test results, patient instructions), billing information and other facility communications (*e.g.*, patient surveys) be communicated to you via the alternative mailing address, phone number and/or email below.

Yale New Haven Health (YNHH) and/or Yale Medicine (YM) (collectively "we" or "our") are not required to agree to this request and only reasonable requests to receive confidential communications will be accepted. If accepted, the confidential contact information will be available for all treating clinicians utilizing the Epic medical record system. It will be the responsibility of the patient to place a similar request with other external organizations.

If the request is accepted, I understand this request for confidential communications will apply to all future communications, unless I request a change to this information.

| **Patient Name (First, MI, Last Name):** | |
|---|---|
| **Date of Birth (MM/DD/YYYY):** | **Request Date:** |

**Alternative Communications Requested (NOTE: only U.S. addresses and phone numbers will be accepted)**

☐ Alternate Mailing Address: _____
Street

_____
City/Town State Zip Code

***Please note:*** If mail to the alternative mailing address is returned as undeliverable, we reserve the right to terminate use of this alternative mailing address and request a new address be provided.

☐ Alternate Phone Number: _____

☐ Alternate Email: _____

_____ _____
**Signature of Patient or Authorized Representative**** **Date**

*If not patient, please indicate relationship:*

_____
***Must provide proof of legal authority (except parent of a minor)*

**Please complete and submit a copy of this form to PatientIdentity@ynhh.org**

**Interpretation Services (if necessary):** An interpreter facilitated the communication between the health care provider(s) and the patient or authorized patient representative in _____ (language) to assist in obtaining informed consent or sharing/acknowledging information.

The interpreter conveyed the content of the original information expressed by and for both parties.

Time: _____ AM/PM Date: _____

**Check here if:** ☐ Telephone ☐ Video ☐ In person ☐ Bilingual Competency Program Approved Staff

**ID Number** (telephone/video only): _____

_____ Print Name of Interpreter

_____ Signature of **Interpreter (in-person only)**



YHS000511 (N 01/23)
Available in Spanish