

Yale University School of Nursing Form
Request Confidential Communications of PHI

MRN# _____

Yale University is committed to providing high quality patient care. As such, Yale believes that complete and accurate information should be readily available to all staff in performance of their duties and that barriers to efficient quality care should be eliminated. Since restrictions placed on the communications of your health information may interfere with the timely provision of patient care, Yale strongly discourages this practice.

However, Yale also recognizes that unique personal situations may cause you to request confidential communication of your health information. Yale believes that you should be aware of some issues that may result from confidential communications. Although Yale will strive to minimize the possibility of these issues arising, we are requesting that you read and acknowledge receipt of this information:

- Any request we accept will not apply when your information is needed to provide you with emergency treatment.
- Any request we accept will be limited to information under our control. For example, this does not include information sent to you from your insurance company.
- We have the right to terminate any agreed upon request by informing you of the termination in writing. Any such termination will only apply to information created or received after we have informed you of the termination.
- Completion of this form will restrict the release of the designated information from the originating department only. It will not assure that communications from health care providers or staff in Yale departments, clinics or laboratories other than the originating department or clinic will be redirected. It is the responsibility of the patient to inform all clinical areas within Yale from which he/she is receiving treatment of this request. It is also the responsibility of the patient to inform all health care providers that are not within of this request.

Complete this form to acknowledge that issues associated with confidential communication of your health information have been read and that you request the this change in communication. You have the right to request us to terminate confidential communication to the extent that such termination applies to information created or received after the date of termination.

Patient Name: _____	
Address: _____	
Town/City: _____	State: _____ Zip: _____ Telephone #: _____
Send information specified below by the following alternative means or to the following alternative address/telephone number:	
Information: _____	

Date Effective: ___/___/___	Date Terminated: ___/___/___

SIGNATURE OF INDIVIDUAL OR
PERSONAL REPRESENTATIVE _____ Date: ___/___/___

I HEARBY REQUEST CONFIDENTIAL COMMUNICATION MARKED ABOVE TO BE TERMINATED:
SIGNATURE OF INDIVIDUAL OR
PERSONAL REPRESENTATIVE: _____ Date: ___/___/___

FOR OFFICE USE ONLY	
We have accepted the above request for confidential communications. Any exceptions are listed below: We are unable to accept the following request:	

By this form being sent to you, we are informing you that the above requests are being terminated	
SIGNATURE OF LICENSED HEALTHCARE PROFESSIONAL: _____	DATE: ___/___/___
PRINT PROVIDER NAME: _____	CLINIC NAME: _____

Copies to: Patient Chart Patient