MRN#____________________

Request Confidential Communications of PHI

The 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 apply to all providers using our Epic medical record system. It is also the responsibility of the patient to inform all health care providers that are not users of the Yale University and Yale New Haven Health medical record 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 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.

Name of Patient:	Effective Date:
Date of Birth:	

Send information specified below by the following alternative means or to the following alternative address or telephone number:

Information:	
Address:	Telephone:
City/Town, State:	Zip Code:

______________________________ __________ OR ____ ________
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

____
Relationship to Patient

I hereby request confidential communication restriction(s) marked above to be terminated.

______________________________ __________ OR ____ ________
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

____ ____
Effective Date of Termination Relationship to Patient

Request Confidential Communications of PHI
(to be completed by Department Staff)

Patient Name:
MRN #:

For Office Use Only:

- ❑ We have accepted the confidential communication restriction(s) you have requested above. Any exceptions are listed below.
- ❑ We are unable to accept the following restrictions you have requested:

  ____

  ____

- ❑ By this form being sent to you, we are informing you that the above restrictions are being terminated.

Signature of Licensed Healthcare Professional: ______________________
Date: ______________
Print Provider Name: ______________________
Clinic Name:

Original to:

- ❑ Patient Chart

Copies to:

- ❑ Patient
- ❑ Privacy Officer