YALE UNIVERSITY SCHOOL OF MEDICINE

YNHH MRN#_____

IDX Account Number: X _____

Request Confidential Communications of PHI

The Yale School of Medicine is committed to providing high quality patient care. As such, YSM 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, YSM strongly discourages this practice. However, YSM also recognizes that unique personal situations may cause you to request confidential communication of your health information. YSM believes that you should be aware of some issues that may result from confidential communications. Although YSM 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 the PHI originating department only. It will not assure that communications from health care providers or staff in YSM 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 YSM 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 <u>not</u> within YSM 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:

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

Patient Name:	
YNHH MRN #:	**IDX Account #: X**

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
❑ YSM Deputy Privacy Officer

Form #: YSM HIP10
Original Date of Form: Effective Date: April 14, 2003
Revised Date: April 11, 2003