Request Confidential Communications of PHI

Confidential communications afford patients the ability to request a different address, phone or email address be used to communicate with the patient. Complete this form to request the additional a confidential address and contact information. Once entered, the confidential contact information will be available 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.

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

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: