Date: _____

SSM HOME CARE

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

RE: REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Printed Name: _____

Patient Social Security #: _____

I understand that SSM Health Care may use and disclose Protected Health Information without my consent for purposes of treatment, payment and health care operations. I request to receive communications of Protected Health Information from SSM Health Care by alternative means or at alternative locations in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that this request may involve additional payment to cover the costs of implementing the confidential communication and I agree to be responsible for this additional cost.

I understand that SSM Health Care is not required to agree to this request for confidential communications and I understand that if this request entails additional cost to SSM Health Care, then I shall be responsible for those additional costs. If I do not provide payment to SSM Health Care for such additional costs, I understand that SSM Health Care has no obligation whatsoever to honor my request for confidential communications.

Specifications: Please complete all of the following:

(1) Please identify the alternative means or alternative location(s) of communication you request:

_____
_____
_____
_____
_____
_____

(2) I understand that no request for confidential communications, except those specified above and agreed to in writing by SSM Health Care, will be effective.

Patient Signature:_____ Date:_____

(3) If you are not the individual who is the subject of this Protected Health Information, you may request a confidential communication only if you are the "personal representative" of the individual as that term is described in the HIPAA Privacy Rules and/or determined

under _____ law. To assist us in determining whether you are a personal representative, please fill in the following:

Your printed name _____

Relationship to the individual:

___ Parent of the individual, who is under the age of 18.

___ Other (Attach written evidence of authority.)

Signature: _____ Date: _____

Address:_____

_____

Phone Number: _____

For Office Use Only:

- ❑ We have accepted the confidential communication you have requested above. Any exceptions are explained in an attached letter:
- ❑ We are unable to accept the confidential communication you have requested. Please contact Privacy Officer [*supply site name, address, and phone number and/or e-mail/web site*] if you have any questions.
- ❑ We are informing you that the above request for confidential communications is being terminated effective: _____.

Signature of Authorized Representative: _____

DATE_____ TITLE_____