DePaul Community Health Centers

PERMISSION TO RELAY INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information (PHI) be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must provide an alternative address or other method of contacting you. ***Some method of contact must be provided***.

DePaul Community Health Centers will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

DePaul Community Health Centers also utilizes 3rd party entities to disclose certain PHI, including 3rd party medical record coordination, health information exchanges (HIE) with local hospitals and medical providers, and the patient portal.

We disclose your PHI for public health and research purposes, to an HIE, and other business associates as permitted by the Privacy Rule, 45 C.F.R. § 164.504(e).

This request supersedes any prior request for communication of information submitted prior to the date below.

EXTENDED AUTHORIZATION

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name (First and Last)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

RESTRICTIONS ON COMMUNICATION METHODS

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do **NOT** want to receive communications:

□ No calls to phone number(s): _____
□ No messages or voice mails left on phone number(s):
□ No mail to the following address: _____
□ 3rd Party Medical Record Coordination
□ Health Information Exchange (HIE)
□ Patient Portal
□ Other (please specify): _____

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient