


<p>Patient Name: _____</p> <p>Date of Birth: _____</p> <p>Medical Record#: _____</p> <p>Place Patient Label</p>	<div> RUSH</div> <p>Rush Copley Medical Center</p> <p>PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATION</p>
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INSTRUCTIONS: You have the right to request how we communicate about all or part of your protected health information by alternative means or to an alternative location. (Note: This request is limited to the department in which you make the request)

Patient Information – please provide us with the following information about the patient:

_____ Last Name	_____ First Name	_____ Middle Name
_____ Street Address	_____ City	_____ State
_____ Zip Code	_____ X X X – X X - Last 4 SSN	_____ Date of Birth
_____ Patient Signature	_____ Date of Request	_____ Phone Number

Personal Representative – if you are the patient's personal representative, please provide your information below:

(Note: If a personal representative is making this request, please attach certifying documentation of your status as the personal representative, such as a Power of Attorney or Guardianship papers)

_____ Last Name	_____ First Name	_____ Middle Name
_____ Personal Representative Signature	_____ Date of Request	_____ Relationship to Patient

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

_____ Department Name	_____ Department Location
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Identify the protected health information you want to make subject to confidential communication:

<input type="checkbox"/> Lab Results	<input type="checkbox"/> Billing
<input type="checkbox"/> Treatment Information	<input type="checkbox"/> Other: (please explain): _____

How do you wish for the department to communicate with you? ☐ Phone ☐ Postal Mail

When completed, please return this form to:
Rush, ATTN: Privacy Office, 707 South Wood St., Suite 317, Chicago, IL 60612-3833
Telephone: (312) 942-5303 Fax: (312) 942-6875