Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

ADMIN • REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Stanford Health Care and Stanford Children's Health (the Hospital) consider all your medical and billing information to be confidential. You have the right to request that we communicate with you about medical and billing matters by an alternative method or at an alternative location. The Hospital's Privacy Office will review all requests and accept those that we can reasonably accommodate. We will not ask you the reason for your request, but we may ask questions regarding how payment will be handled. Your request will be in effect until you change or rescind it by submitting a new copy of this form.

I am requesting that an alternative method or location be used in communicating with me about all of my medical and billing information regarding treatment I receive from this date forward. I understand that communications regarding prior episodes of care may use addresses or phone numbers provided at that time.

❑ New Request ❑ Change Prior Request ❑ Withdraw Prior Request

Please check which information you are requesting to be changed	Use This Information
❑ Mailing Address	
❑ Billing/Guarantor Address, if different	
❑ Telephone	
❑ Hospital Physicians to be notified	

*The Hospital does not routinely use e-mail or fax to communicate with patients

The Hospital will update its information systems using the information you have provided. Please note, this request will not be communicated to anyone outside of the Hospital, such as your insurance company, health plan, employer, community physicians treating you or researcher conducting a study in which you are participating.

DATE _____ TIME _____ SIGNATURE (Patient /Legal Designated Representative) _____

PRINT NAME _____ RELATIONSHIP TO PATIENT _____

Received by (Staff): _____
(Print Name)

If an interpreter participated in the discussion:

PRINT SHC in-person interpreter name _____ Video or TEL Interpreter ID# _____ Language _____

If you have additional questions regarding this request, please contact our Privacy Office (300 Pasteur Drive, MC 5780, Stanford, CA 94305-5202 or 650-724-2572. This form can also be faxed to 650-723-3628.

Internal Use Only

Date Received by Privacy Office: _____ Date Reviewed: _____

Request: ❑ Approved ❑ Denied Date Notification Sent to Patient: _____