

Alternative Confidential Communication Request Form

As described in UW-Madison policy UW-121, you can use this form to request that the University of Wisconsin-Madison communicate your Protected Health Information ("PHI") to you by alternative means or at an alternative location.

- Your request may be denied if it cannot be reasonably accommodated.
- If granted, your request will apply only to PHI communicated by UW-Madison and its business associates.
- Be aware that if urgent contact is required, staff may use any available contact information to reach you.
- If you choose to change your method of communication again in the future, you must resubmit this form with the new information. For information on how to revoke this request, see reverse.
- This form DOES NOT authorize the sharing of your PHI with any other individual. A separate HIPAA authorization form must be completed.

1. Patient/subject identification

Name – Last, First, MI		Birthdate (MM/DD/YYYY)
Street Address		
City	State	Zip Code

2. I request that UW Madison communicate my protected health information with me through the following alternative means or locations:

- ☐ Alternate Address: _____
- ☐ Alternate Phone Number: _____
- ☐ Other Alternative Means (specify): _____

BEFORE SIGNING PLEASE SEE REVERSE FOR ADDITIONAL INFORMATION ON YOUR RIGHTS

I authorize the communication of my protected health information to the alternative means described above.

Signature of patient (or legally authorized representative): _____ Date: _____

If signed by person other than patient/subject, state relationship and authority to do so. (See reverse for information about signatures.)

Name and Relationship: _____

Individual Is: ☐ Minor ☐ Incapacitated ☐ Deceased

Legal Authority: ☐ Guardian ☐ Parent of Minor ☐ Spouse of Deceased
☐ Active Health Care Power of Attorney ☐ Personal Representative of Deceased

Additional Information About This Request and Your Rights

There are federal and state laws that protect your medical information. Before signing, please read the following to ensure you understand how these laws and regulations apply to this request and your medical information.

Revocation. You have the right to revoke this request at any time. Your revocation must be made in writing and submitted to your health care provider/clinic.

Signatures. Generally, if you are 18 years of age or older, you are the only person permitted to sign this form. If you are under the age of 18, in most circumstances your parent or guardian must sign this form for you. However, there are situations in which these general rules do not apply. For more information on these exceptional situations, contact the UW-Madison HIPAA Privacy Officer (contact information below).

Additional Rights Under HIPAA. HIPAA also provides additional rights that don't just apply to this request. If you would like additional information on these other rights, you can review the Notice of Privacy Practices that you were provided by your clinic or contact the Privacy Officer with the contact information below.

UW-Madison HIPAA Privacy Officer
361 Bascom Hall, 500 Lincoln Drive
Madison, WI 53706
hipaa@wisc.edu
www.compliance.wisc.edu/hipaa