HARRISHEALTH SYSTEM

Request for Confidential Communication of Protected Health Information

I, _____, request communication of

_____

_____

_____

by Harris Health System by alternative methods or at alternative locations. I understand this request applies only to the above communications from Harris Health System to me and, if applicable, to the named insured of an insurance policy that covers me as a dependent of the named insured.

Patient's Signature_____ Date _____

Printed Name _____

Patient's Date of Birth _____ Patient's MR# _____

Please indicate the methods and/or locations where we may contact you or provide you other written communication.

Telephone Number_____

Mailing Address_____

Other Contact Information_____

Additional Instructions_____
(use additional paper if necessary)

NOTE: This request will remain in effect until you notify Harris Health System in writing requesting a change.

Return complete forms to: Harris Health System, Attn: Privacy Officer, 4800 Fournace Place, Bellaire, Texas 77401.