UNITE HERE HEALTH

Request for Confidential Communications

For Use and Disclosure of Protected Health Information (PHI)

Complete and mail this form to:
Privacy Officer
UNITE HERE HEALTH
P.O. Box 6020
Aurora, Illinois 60598-0020
(866) 711-4373

Participant Name _____

Participant SS# _____

Request for Confidential Communications

Patient Name _____ **Patient SS#** _____

Patient Date of Birth _____ **Relationship to Participant** _____
(month-day-year)

In completing this form, you are requesting changes or limitations relating to communications from UNITE HERE HEALTH. If your request is approved, we are bound by the terms of the agreement. If your request is denied, UNITE HERE HEALTH will provide a written explanation of the reasons for the denial, and information regarding how you may file a complaint. Until a decision is reached, your request will not be effective.

If this request is approved, this change will remain in effect until you notify us otherwise.

I request the following changes or limitations relating to communications directed to me by UNITE HERE HEALTH:

Send All Communications to:

_____ ( ) _____
First Name Last Name Telephone

_____
Street Apt#

_____
City State Zip

Reason for Request _____

_____

_____

❑ Disclosure of my health information to any address other than that detailed above could cause me harm (check if applicable).

_____
Signature of Patient (parent or guardian if the patient is a minor) or Personal Representative Date

_____ ( ) _____
Printed Name Phone Number Where We May Contact You

_____
Relationship to Patient

For UNITE HERE HEALTH Use Only:

❑ Accepted ❑ Denied

Privacy Officer Signature: _____ Date: _____

Dept. Manager Signature: _____ Date: _____