Name of Policy: Patient request for confidential communications

Policy Number: 3364

(a) UTMC and its healthcare components will permit an individual to request confidential communication by an alternative means or at an alternative location.

(b) The individual may make the request without having to change their primary contact information on file and for a specified period of time if applicable.

(c) UTMC or its healthcare components may not require an explanation from the individual for the basis of the request as a condition of granting the request.

(d) UTMC or its healthcare components, in appropriate circumstances, may condition the grant of a request for confidential communication upon a satisfactory payment arrangement to cover the cost of the communication.

(3) Documentation

(a) Individuals complete/or review the "request for confidential communication" form annually. Patient may make changes by submitting a new "request for confidential communication" form to HIM.

(b) HIM will evaluate the request and may grant the request if reasonable.

(c) Where the means or locations contained in the request involve incurring costs over and above the usual costs of such communications, the request may be granted if a payment arrangement is agreed upon with the individual.

(d) A request for confidential communications which is not made in person may be granted subject to the verification of the identity of the individual making the request in addition to other previously addressed conditions.

(e) A request must be documented if given orally by completing a "request for confidential communication" form on behalf of the individual, in addition to other documentation sufficient to support a finding that an oral request was made. If this is an emergent situation where a patient cannot be physically present to make the request, documentation from the requestor will be required, such as power of attorney for healthcare.

(f) If the form is filled out on behalf of the individual, the individual must be made aware of his/her responsibilities with respect to payment (if applicable), accuracy of information provided and notice to UTMC should any of the information provided change.

(D) Definitions

(1) Covered component(s) or designated health care component – the university of Toledo medical center, the UT medical staff, UT clinics (including the university of Toledo student and employee health clinics), the entire health science campus and

Approved by:

/s/

Gregory Postel, MD
President

Date: September 13, 2023

Review/revision completed by:

Privacy and Security Committee
Senior Leadership Team

Policies superseded by this policy

None

Original effective date:

November 15, 2010

Review/revision date:

September 1, 2013
September 1, 2016
October 6, 2020
September 13, 2023

Next review date:

September 13, 2026

Request for Confidential Communication of Protected Health Information.
Privacy Office
3065 Arlington Avenue Mulford Library 224
Toledo, Ohio 43614 419 383-4994

Patient Name: ______________________________ Birth date: ____________________

MRN: ____________________

I request that my protected health information be disclosed via

☐ E-mail (Specify e-mail address) ______________________________________

☐ Telephone (Specify phone number) ______________________________________

☐ Leave voicemail if no answer ☐ Do not leave voicemail if no answer

☐ Regular mail (Specify address) ______________________________________

☐ Instant Messaging (Specify address) ______________________________________

☐ Express mail/Courier (Specify address-charges may apply)

____

I request to have my protected health information disclosed by the method selected above from:
☐ Until further notice

☐ From ________________________ to ________________________ (dd/mm/yyyy)

I understand that UTMC is not required to grant my request and in some cases my request will only be granted if I agree to pay for the cost of the communication. I affirm that the contact information provided is accurate to the best of my knowledge. I understand that it is my responsibility to notify the UTMC of any changes to my contact information or if I no longer wish to be contacted via the method requested on this form.

______________________________________ ____________________
Signature of Patient/Legal Representative (relationship) Date

Please indicate below if you would like to receive a copy of our "**Notice of Privacy Practices**"

(Also available online at utmc.utoledo.edu/patient guests/services/privacy).html