



Request for Confidential Handling of Protected Health Information

Patient Name: _____

Last First MI Maiden or Other Name

Date of Birth: ____ - ____ - ____ Medical Record #: _____ Phone: _____

Address: _____ City: _____ ST: ____ Zip: _____

I request confidential handling of communications to me regarding my protected health information:

- For all health information
- Only for health information related to a particular illness or injury _____
- For a specified time period: From _____ To _____
- For billing matters only.

Communication of protected health information to me should be handled in the following way:

- Mailed to an alternative address: _____
- Via Email only: _____
- To an alternative telephone number: _____
- Other (please specify): _____

I understand that Concentra has the right to deny my request if it would be difficult to administer. I agree if this request impacts how payment is made for health care services provided to me, I will guarantee payment of these services by paying for it in full at the time of request (unavailable to workers compensation).

SIGNATURE OF PATIENT

DATE

OR

PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON

DATE

RELATIONSHIP TO PATIENT

You may submit this form:

- In person: to the nearest Concentra medical center
- By mail: Concentra Privacy Office
P O Box 1438
Louisville, KY 40202-1438
- By fax: 502.508.3700
- By email: PrivacyOffice@concentra.com

FOR INTERNAL USE ONLY
 Complete the section below then
 Email this request to PrivacyOffice@Concentra.com
 or fax to 502.508.3700

Staff member who processed request

Title

Phone

Date completed

Center Name

Location Number

