## **Concentra**°

## **Confidential Handling Request Form**

**Please Review Prior to Completing:** This form is used to request an alternate method of communication (that is, a different email, phone number, or address) other than what is on the file for confidentiality reasons. It should not be used when a patient wants to get a copy of his/her medical record or designate another person to receive his/her medical record.

Patient Name:					
Date of Birth:	Last Medical Re	Fir ecord Number:		MI Phone:	Maiden or Other Name
Address:			City:		St: Zip:
Facility Visited:					
I request confidentia	al handling of communica	tions to me regarding	my protected heal	th information (	PHI):
For all health infor	mation				
Only for health inf	ormation related to a partic	ular illness or injury:			_
For a specified tim	ne period from	to			
For billing matters	only				
Communicating my	PHI to me should be hand	dled in the following w	ay:		
Mailed to an altern	native address:				
Via email only			. [Mark an X here _	if you prefer	the email is sent unencrypted.]
To an alternative t	elephone number:				
Other (please spe	cify):				
	confidential handling cannot be a confidential handling cannot be a confident by	ot apply to workers' com  Date  Or _		dian/Authorized Perso	on Date
		-	Dalation	ahia ta Datiant	
For the most efficient processing			Relationship to Patient		
	npleted form directly to the ontact information (phone r				
			burg, PA 17055		
FOR INTERNAL USE OF Facility: Refer to application	<b>NLY</b> ble internal procedure. Contac	t the Concentra Privacy Of	fice with questions.		
Notice of Decision:					
Confidential Handling:	Completed Denied				
If denied, reason for de	enial is:				
Concentra is unable	to accommodate the request.				
Other					
Leadership Colleague	Handling Record Review	Title		Phone	Date Completed
Facilit	ty Name				