OptimaHealth

REQUEST FOR PHI TO BE COMMUNICATED BY ALTERNATE MEANS OR LOCATION

_____ _____ _____
Individual's Name Member ID Date of Birth

I _____ request that Optima Health***:***

☐ Send my protected health information to an alternative address:

Mail to: _____
First Name MI Last Name

_____
Street Address Apartment #, if any

_____
City State Zip Code

☐ Use an alternate method of communicating my protected health information:

Method of Communication including how I can be reached: _____

_____

I understand that I may revoke or change this request at any time by writing to ***Optima Health***; however, ***Optima Health*** will use on this authorization until it receives the written notice of revocation or change.

I understand that I am still responsible for my part of the payment for services provided. Payment notice is to be sent to my alternate location, to the location below, or by the method below:

Location or Method of Communication of Payment Notice if different than above:

_____

_____ _____
Signature of Individual Date

_____ _____
Signature of Personal/Authorized Representative, Parent or Guardian Date

The above request for communication of protected health information by an alternate means or alternate location is: □ Approved □ Not Approved

Reason for not approving the request: _____

_____ _____
Staff Signature Date