

**TRANSMISSION OF CONFIDENTIAL COMMUNICATIONS
REQUEST FORM**

PATIENT'S NAME: _____

TO BE COMPLETED BY THE PATIENT: Please complete the following if you are requesting that **QUE Financial** provide communications containing your "Protected Health Information" to an alternative address or by alternative means.

I request that communications from **QUE Financial** to me that identify my Protected Health Information be directed to the following address or phone number, or by other means as described below:

If **QUE Financial** is unable to contact me at the above address or phone number, **QUE Financial** may direct communications that identify my Protected Health Information to the following alternative address or phone number: _____

I understand that **QUE Financial** may condition approval of my request upon my providing information as to how payment for services will be handled, and/or my specification of an alternative address or other method of contact in addition to the address or method of contact requested above:

Responsible Party's: _____

Date of Request: _____

To be completed by QUE Financial:

Request for alternative communications is: Denied Approved

Comments: _____

Date

Signature of HIPAA Compliance Liaison