THE UNIVERSITY OF TEXAS AT DALLAS
CALLIER CENTER FOR COMMUNICAITON DISORDERS

REQUEST FOR ALTERNATE CONFIDENTIAL COMMUNICATIONS OF MEDICAL INFORMATION

Name: _____ Daytime Phone # _____

Address: _____

DOB:_____ Email address:_____

Description of the means by which and/or location to which you want the Callier Center to provide you with communications containing Protected Health Information: _____
_____
_____

Description of the medical information to which the communications method will apply (check one):

- ☐ All medical information pertaining to the individual identified above
- ☐ Other. Please specify: _____

If this restriction would affect our ability to provide treatment or collect or make payments in connection with your health benefits, please explain how this would be handled under the proposed restriction:

_____
_____

Could disclosure of medical information other than as requested endanger you?
Check one: ☐ Yes ☐ No

Signature: _____ Date: _____

If the request is signed by a legal representative of the individual:

Printed name of legal representative: _____

Representative's authority to act for the individual: _____

If signed by a legal representative of the individual, please note that we must verify that you are this individual's legal representative for purposes of filing this Request. Please enclose any documents that support this authority (Power of Attorney, Court Order, etc). As this person's

representative, can you be contacted at the address, e-mail, or phone number listed above? If not, please provide your mailing address, e-mail address and phone number below:

_____

_____

_____

For Callier Center Use Only

Person processing request: _____

Date request received: _____

Request: ☐ Granted ☐ Denied Date individual notified: _____

Method and destination of notification: _____