Request for Alternate Communications

I hereby request that the protected health information detailed below be sent by alternative means or to an alternative location. I understand your organization may place conditions on the request based on payment arrangements and specific information regarding the alternate address or method of contact.

Please be aware that we will make a reasonable and good faith effort to meet your request for delivery of information by an alternate means or method. However, if this request impacts how payment is made for health care services provided to you, you will guarantee payment of these services by paying in full at the time of the request.

Please describe the specific situation and information that requires an alternate communication method:

_____

_____

_____

Please describe the preferred method to accommodate your request:

_____

_____

_____

What is the requested length of time for this alternate communication? _____

Please print the following information:

Name: _____ Date of Birth: _____

Daytime Phone: _____

Alternate Phone: _____

Address: _____

_____

_____

Signature: _____ Date: _____

Signature of Legal Representative

Only if individual is incompetent*: _____ Date: _____

If signed by Legal Representative, relationship to individual: _____

***If signed by Legal Representative, must provide representative documentation as required by state law, i.e., Health Care Power of Attorney, Health Care Surrogate, Living Will or Guardianship papers.**

To prevent a delay in fulfilling your request, please verify that all fields on the form are accurately completed. If information is missing, the form will be returned to you for completion.

Please attach a separate sheet if additional space is needed.

Please send this form to:
Harris, Rothenberg International, Inc. dba Humana EAP and Work Life Services,
100 William St., 10th Floor
New York, NY 10038

This organization follows the more stringent of all federal and state laws and regulations.