Philadelphia FIGHT Community Health Centers

REQUEST FOR CONDITIONS ON CONFIDENTIAL COMMUNICATIONS

You are being asked to complete this form because you have asked FIGHT to communicate with you by alternative means or at alternative locations. FIGHT will honor all reasonable requests to receive communications of protected health information (PHI) by alternative means or at alternative locations.

Patient Name:____ DOB:_____________

What information would you like communicated by alternate means or to an alternate locations?

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Describe the requested alternative means (such as location/address/telephone number/e-mail which will be sent encrypted and securely):

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This Request made by (Check One):

☐ SELF Request - Adult or Adolescent Patient 13 years of age or older

☐ Legal Guardian/Parent Request
Guardian/Parent Name:___________________________________ Guardian/Parent DOB:_____________

☐ Patient's Legally Authorized Representative Request - complete below
Representative Name:_________________________________ Representative DOB: _____________
Description of Legal Authority to act for the Patient:
____

____ _____________
Signature of patient or patient's Legally Authorized Representative Date
(Form MUST be completed before signing.)

FOR INTERNAL FIGHT USE ONLY
Staff must email this request form to FIGHT's Privacy Officer at privacy@fight.org, within ten (10) days of receipt of request.

This form can be submitted in person at any Philadelphia FIGHT Health Center, via email to privacy@fight.org, via fax 215-732-1145 Attention: Privacy Officer, or via mail Philadelphia FIGHT Privacy Officer, 1233 Locust St. 5th Floor, Philadelphia PA 19107.