Salem Health Hospitals and Clinics

Request for Confidential Communications Regarding Protected Health Information

PATIENT CONTACT INFORMATION

Patient Name: ______ Date of Birth: ______

Phone #: ______ Medical Record # (*optional*): ______

Street: ______ City: ______ State/Zip: ______

REQUEST

I request to be communicated with using an alternative means. When Salem Health contacts me or my personal representative to provide any information about my health care condition, treatment, or payment, Salem Health should use the confidential communications described below:

PLEASE DESCRIBE THE ALTERNATIVE COMMUNICATION CHANNEL OR METHOD TO BE USED

______

______

______

______

Signature of Patient or Legally Authorized Representative ______ **Date** ______

Personal representative name: ______

Relationship to Patient: ______

This request does not guarantee that all Salem Health providers who previously collected contact information from you will receive this request. You are responsible to address your communication concerns at the time and location where you received services.

Please return completed form to: Salem Health Privacy Officer
Corporate Integrity Office
P.O. Box 14001
Salem, OR 97309-5014

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