

CONFIDENTIAL COMMUNICATION REQUEST

Policy No.: _____

Insured's Full Name: _____ Insured Birth Date: _____

Address: _____

SSN: _____

I am requesting that American Community send my protected health information to a confidential location.

If approved please indicate the name and address of where you wish this information to go.

Signature

Date

FOR AMERICAN COMMUNITY'S USE ONLY:

Patient Name: _____

Date Request received: _____ Status: ___ Accepted ___ Denied

If denied, reason for denial _____

Name of Staff Member: _____ Completed: _____