REQUEST FOR MORE CONFIDENTIAL COMMUNICATIONS

Patients may request more confidential communication of their health information that involves more than a change of address. Each request will be reviewed, but is subject to the limitations outlined in the federal standards for Privacy of Individually Identifiable Health Information and the ability of this facility to meet the request. You are not obligated to explain why you are requesting this change in method or location of receiving communications, but we may be able to protect your health information better if we know more about your circumstances.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address to which response should be sent:</td>
<td>Phone #</td>
</tr>
<tr>
<td>Verification of Identity</td>
<td>Medical Record Number</td>
</tr>
</tbody>
</table>

** Complete the following only if the person making the request is not the patient:

<table>
<thead>
<tr>
<th>Name of Requestor</th>
<th>Relationship to Patient</th>
<th>Legal Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of Identity</td>
<td>Verification of Authority</td>
<td>Phone #</td>
</tr>
</tbody>
</table>

I AM REQUESTING A DIFFERENT METHOD OR LOCATION FOR RECEIVING MY PERSONAL HEALTH INFORMATION:

Health information affected by request: ____________________________________________________________

Current method or location for communication is: __________________________________________________

Check one or both of the following, and be as specific as possible concerning your request.

___ I am requesting that the method of communication be changed to: ________________________________

___ I am requesting that the location of communications sent to me be changed to: ______________________

I AGREE TO THE FOLLOWING STATEMENTS:

- The University of Florida (UF) is not obligated to agree to my requests for special privacy protections as outlined above. I will receive a response in writing after the request has been reviewed.
- In emergency circumstances, even if a special privacy protection has been agreed to, UF may still use and disclose necessary information to treat me/the patient.
- A special privacy protection agreed to by UF will not prevent uses or disclosures required by law.
- Special privacy protections agreed to by UF may be terminated at any time, with written notice from either party.

Signature:  Patient or Representative

Date of Request:

Complete all parts of the form, then sign and date it. Keep or request a copy for your records. Give, fax, or mail the original form to the UF Privacy Office or your doctor or other health care provider.

Email: privacy@ufl.edu  Mail: PO Box 113210, Gainesville, FL 32610  Fax: 352-392-6661