KINGS VIEW

ALTERNATIVE MEANS OF CONFIDENTIAL COMMUNICATION

This form applies only when a client requests a special manner of communication based on confidentiality concerns. This form is NOT to be used merely to notify Kings View of a change in address or other contact information.

I. REQUEST

Date: _____

Client name: _____

Date of birth: _____ Medical Record #: _____

You may request to receive confidential communications of your protected health information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

You do not need to tell us the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or other method of contacting you (phone number, e-mail address, etc.). Please specify how or where you wish to be contacted:

_____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(Client/legal representative)

If signed by someone other than the client, indicate relationship: _____

Print name: _____
(Legal representative)

RETURN this form to the Kings View facility where you receive(d) services.

For more information about your privacy rights-

- See the *Notice of Privacy Practices* available on our website at www.kingsview.org or
- Obtain a copy of the *Notice of Privacy Practices* at the facility where you receive(d) services.

If you believe your privacy rights have been violated, you may file a complaint. *You will not be penalized for filing a complaint.*

(OVER)

Medical Record #: _____

To file a complaint with Kings View, call or write the Privacy Officer. All complaints must be submitted in writing to:

Kings View
Attention: Privacy Officer
7170 N. Financial Drive, Suite 110
Fresno, CA 93720
Phone (559) 256-1080

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
Office of Civil Rights
90 7th Street, Suite 4 – 100
San Francisco, CA 94103
Phone (800) 368-1019
TDD (800) 537-7697

II. RESPONSE

_____ Request APPROVED _____ Request DENIED

By: _____ _____
Print Name *Title*

_____ _____
Signature *Date*

Reason for Denial:
_____ Administratively impractical to accommodate request.
_____ You failed to provide information as to how payment, if applicable, will be handled.
_____ You failed to specify an alternative address or method.
_____ Too expensive to accommodate request.
Additional explanation:

_____
_____

III. CLIENT NOTICATION

Date Notified: _____ Method: _____ Mail _____ Telephone _____ In Person

By: _____ _____
Print Name *Title*

_____ _____
Signature *Date*