american greetings

Request for Alternative Communications Regarding Protected Health Information

Purpose: This form is used for an individual's request that American Greetings use alternative means or an alternative location when communicating about protected health information to avoid endangering the individual.

SECTION A: Individual Requesting Confidential Communication

Individual's Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

SECTION B: To the Individual – Please read the following and complete the information requested

You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if it is reasonable, you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, you provide reasonable alternative means or location for communicating with you, and you provide a satisfactory explanation how any applicable premium or other payments will be handled under the alternative means or location you request. We will not investigate the validity of your claim that failure to communication with you by the alternative means or location could endanger you. To exercise this right, please complete this Section B.

Please explain why you request confidential communication about your protected health information by alternative means or to an alternative location:

_____

_____

Please describe the protected heath information you want to make subject to confidential communication:

_____

_____

_____

Please explain how any applicable premium or other payments will be handled:

_____

_____

_____

SECTION C: Method of Communication

☐ I request that you communicate with me about my protected health information at the following alternative address. Please provide full information on the alternative location:

_____

_____

_____

☐ I request that you communicate with me about my protected health information by the following alternative means. Please provide full information on the alternative means you want us to use:

_____

_____

_____

Section D: SIGNATURE

I attest that failure to communicate about my protected health information by the alternative means or to the alternative location I request could endanger me.

Patient's Printed Name: _____ **Date:** _____

Patient's Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Patient's Representative Printed Name: _____ **Date:** _____

Patient's Representative Signature: _____ **Date:** _____

Relationship to Individual: _____

Please submit this request to:

American Greetings
AG Benefits Department
One American Blvd.
Cleveland, OH 44145

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

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