|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **REQUEST TO COMMUNICATE BY ALTERNATE MEANS OR AT AN ALTERNATE LOCATION**  King County Behavioral Health and Recovery Division  The Chinook Building  401 Fifth Avenue, Suite 400  Seattle, WA 98104 | | | | |
| Client Name: |  | | | |
| Previous Name: | | |  | |
| Date of Birth: | |  | | |
| KCID (If known): | | | |  |
|  | | | |  |

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), you have the right to request that we communicate with you by alternate means or at an alternate location, ***if you clearly state that the disclosure of all or part of the requested information could endanger you****.*

Please be specific in the information regarding the location or means of communication that you prefer.

|  |  |
| --- | --- |
| Information to be communicated: |  |
|  | |
|  | |

|  |  |
| --- | --- |
| Preferred Means of Communication: |  |
| Mail: | |
| Fax: | |
| Other – Please specify: | |

|  |  |  |
| --- | --- | --- |
| Alternate location for Communications: |  | |
|  | | |
|  | | |
| Telephone number, if you wish to be contacted by telephone: | |  |

|  |  |
| --- | --- |
| Date of Request: |  |
| Your request will be reviewed by the Behavioral Health and Recovery Division (BHRD) Privacy Officer for approval or denial. If your request is denied, you will be notified. | |

I hereby clearly state that the disclosure of the information requested could clearly endanger me.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of person or legal representative |  | Date |

Signature verified by: (driver’s license, notarized, case manager signature, other)

(Completed form may be given to site HIPAA officer or mailed to the BHRD Privacy Officer at the above address. Verification of the identity of the person signing this form will be required.)

|  |
| --- |
| **FOR INTERNAL USE ONLY:**  Identity of client verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If signed by a legal representative, authority verified by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Request has been  Accepted  Denied  Comments (Basis of denial) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Client notified in writing on this date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Staff person processing this request:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |