



Request for Confidential Communications of Protected Health Information

PARTICIPANT PLEASE NOTE: THE PARTICIPANT MUST CLEARLY STATE THAT THE DISCLOSURE OF ALL OR PART OF THAT INFORMATION COULD ENDANGER THE PARTICIPANT. INTER-COUNTY IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Participant Name: _____ Date of Birth: _____

Participant Address: _____
Street Apartment # City, State Zip

Alternate Address: _____
Street Apartment # City, State Zip

Other Method of Contact: _____

Type of PHI to be redirected to the alternate address: _____

Signature of Participant Date

FOR INTERNAL USE ONLY:

Date Request Received _____