Optum

Medical Record Number: _____

The Polyclinic, PLLC dba Optum Care Washington, PLLC

Request for Alternative Means of Confidential Communications

Patient Name:_____DOB:____/____/____

Patient Primary MD:_____Clinic Name/Location: _____

Patient Primary Address:_____City:_____State:_____Zip: _____

I request that The Polyclinic dba Optum Care Washington (OCW) communicate with me by alternative means or at alternative locations for reasons of confidentiality. I understand that OCW will comply with reasonable requests and will inform me directly and in writing if they are unable to comply with my request. OCW will not ask for any reason for this request.

Do you wish to indicate an alternate mailing address: □ Yes □ No (If yes please provide the alternative address)

Street:_____Apt/Unit Number: _____ City:_____

State:_____Zip Code: _____

Do you wish/authorize OCW to contact you via phone: □ Yes □ No

If yes, indicate which number: □ Home Phone □ Work Phone □ Cell Phone: ( ) _____

Additional Method of Contact: _____

Do you authorize OCW to release your information including diagnosis, treatment, medical records and claims information to the individuals listed? □ Yes □ No

If yes, please identify:

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship: _____

Name:_____Phone:_____Relationship: _____

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here_____/_____/_____(date).

I agree that this change will not affect my payment responsibility or processes necessary to obtain payment for OCW services. I understand that, if approved, this request will remain in effect until I terminate or change this request, at any time, by notifying OCW in writing.

Signature of Patient:_____**Date**:_____/_____/_____

If personal representative, print name:_____**Relationship:** _____

Internal Use Only: Name of teammate receiving form:_____Date:____/___/___

Request Approved □ Yes □ No If approved ensure documented in appropriate systems and staff notified If request denied provide reason for denial: _____

If denied patient must be notified in writing with denial reason

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The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities. We provide free services to help you communicate with us such as letters in other languages or large print. Or you can ask for an interpreter. To ask for help, please call 1-206-329-1777, TTY 711. ATENCIÓN: Si habla español, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-206-329-1777, TTY 711. 請注意：如果您說中文, 我們免費為您提供語言協助服務。請致電: 1-206-329-1777, TTY 711.