REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI) BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATION

Clear Fields

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LEGAL DIVISION
SFN 1977 (10-2022)

The North Dakota Department of Health and Human Services and its authorized agents (Department) will communicate with you at the primary address and phone number on record with the Department. You have the right to request the Department communicate your protected health information (PHI) with you on a confidential basis by requesting an alternative means of communication. This form is to be used to make requests to Department health plans, health care facilities, and Department programs providing health care.

The Department is not required to agree to your request, but will make every effort to accommodate your request if:

1. The request is reasonable;
2. The request is permitted or authorized by law;
3. A specific alternative means of communicating with you is provided; and
4. Information is provided as to how any payment will be handled, if applicable.

A Department health plan will accommodate your request if the above criteria is met and you state that failure to honor your request could place you in danger. Your statement of endangerment will not be questioned.

The Department will review your request for approval or denial. If the Department approves your request:

- Communications to the alternative means will be addressed to you;
- The Department will rely on the information you provide;
- A separate request is required for each Department program providing health care, health plan, or health care facility and their agreement must be obtained separately;
- If the Department determines there is an emergency and you cannot be located by the alternative means of communication, or if you have not provided adequate information on how payment will be made, the Department will use any available contact information to locate you;
- The alternative means of communication will begin within five (5) business days from the approval date;
- A legal representative signing this form shall provide documentation of their legal authority; and
- This request and subsequent approval will remain in effect until terminated by the Department or terminated in writing by you.

Risks: The privacy and security of electronic communications cannot be guaranteed. Electronic communications can be intercepted, forwarded, circulated, stored, or even changed without the knowledge of the sender or recipient. There is risk that any PHI contained in electronic communications may be misdirected, disclosed to, or intercepted by an unauthorized recipient. Email addresses and text message numbers can be entered incorrectly resulting in a communication being sent to an unintended recipient. You should not agree to electronic communications unless you are willing to accept these risks.

Conditions of Use: Electronic communications from the Department containing PHI are unencrypted (unsecure). The Department will rely on the contact information you provide. You are responsible for providing the correct information and notifying the Department of any changes to your information. The Department is not liable for electronic communications that are not received due to technical failure or for improper disclosures of PHI that are not a result of our negligence. The Department is not responsible for any fees imposed by your email or text message service provider. Electronic communications may be included in your Department record.

The Department cannot guarantee that an electronic communication will be read and responded to within a specific period of time. The Department does not monitor electronic communications during non-business hours. All communications regarding emergency or crisis situations are to be conducted by phone call or in person.

SECTION 1: CLIENT INFORMATION

Client Name (Last, First, Middle Initial)		Date of Birth	
Address	City	State	ZIP Code
Name of the Department Program Providing Health Care, Health Plan, or Health Care Facility Your Request Applies To			
Telephone Number (if we have questions regarding your request)			

SECTION 2: ALTERNATIVE MAILING ADDRESS OR PHONE NUMBER

a. Provide the address or telephone number (other than your primary address or telephone number) where you want to receive communications.

☐ Alternative Mailing Address	Address		
	City	State	ZIP Code
☐ Alternative Telephone Number	Number	Leave Message ☐ Yes ☐ No	

b. Select or describe the PHI you would like to have communicated using the alternative mailing address or telephone number

☐ All Communications ☐ Appointment Reminders ☐ Billing/Payment Information ☐ Assistance or Service Information
☐ Eligibility Information ☐ Other (describe the PHI in detail):

c. Specify any additional instructions here and explain how payment will be handled if applicable.

d. HEALTH PLAN ATTESTATION OF ENDANGERMENT - Complete this section ONLY if your request is to a health plan and is applicable to your request.

I attest that failure of a Department health plan to communicate the PHI specified in by the alternative means of communication could place me in danger. Initial here:_____

e. All requests for alternative communications must be signed and dated. Requests will not be processed if signature and date are missing.

Signature of Client		Date
Signature of Legal Representative (if applicable)	Relationship	Date

SECTION 3: CONSENT FOR UNENCRYPTED ELECTRONIC COMMUNICATIONS

a. Select the type of electronic communication you wish to receive and provide contact information (check all that apply).

☐ Emails	Email Address
☐ Text Messages	Phone Number

b. Select or describe the PHI you would like to have communicated by the electronic means. NOTE: The Department reserves the right to limit the transmission of certain information through electronic communications.

☐ All Communications ☐ Appointment Reminders ☐ Billing/Payment Information ☐ Assistance or Service Information
☐ Eligibility Information ☐ Other (describe the PHI in detail):

c. Signature and Acknowledgment. Requests will not be processed if signature or date is missing.

I understand that unencrypted (unsecure) means the added security protections that help safeguard the contents of electronic communications are removed. I consent to receive unencrypted (unsecure) electronic communications from the Department.

Signature of Client		Date
Signature of Legal Representative (if applicable)	Relationship	Date

DEPARTMENT USE ONLY
This form is to be included in the client record. The electronic record or respective information processing system must be updated to reflect the request if applicable.

Date Received	Date Processed	Date Notice Sent to Client

Request is	Reason for Denial	
☐ Approved	☐ Request is not reasonable to accommodate	☐ Alternative means not provided
☐ Denied	☐ Failure to explain how payment will be handled	☐ Request is not permitted or authorized by law
	☐ Other (specify): _____	

Printed name of Department Representative	Signature	Date

SECTION 4: TERMINATION

Complete this section if you wish to terminate this request. Requests cannot be modified. To make changes, you must terminate this request and submit a new Request for Confidential Communication of Protected Health Information (PHI) by Alternative Means or Alternative Location.

I understand this termination:

- Applies only to the Department program providing health care, health plan, or health care facility indicated in this request;
- Will go into effect the date the request is received by the Department;
- Will not affect any action the Department has taken in reliance before receipt of this termination; and
- Communications will be sent to the primary address or phone number on record with the Department unless a new Request for Confidential Communication of Protected Health Information (PHI) by Alternative Means or Alternative Location is submitted.

Signature of Client	Date

Signature of Legal Representative (if applicable)	Relationship	Date

DEPARTMENT USE ONLY (TERMINATION)
This form is to be included in the client record. The electronic record or respective information processing system must be updated to reflect the request if applicable.

Date Received	Date Processed	

Printed Name of Department Representative	Signature	Date