DAVIS VISION
EYECARE REFRAMED℠

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Member Information *(Please Print)*

This section must be completed with the information specific to the individual. A contact number or address is needed in case additional information or clarification is required.

Date: _____ **Member ID:** _____
Name: _____ **Date of Birth:** _____
Address: _____ **Telephone:** _____
_____ **Email:** _____

You have the right to request that Davis Vision 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 (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. We will not investigate the validity of you claim that failure to communication with you by the alternative means or location could endanger you. To exercise this right, please complete this form, sign and submit to:

Davis Vision – Privacy Office
P.O. Box 1416
Latham, New York 12110-1416
Fax: 1-866-999-4640

If you have questions, need additional information or assistance in completing your request, please contact the Davis Vision Privacy Office at 1-800-571-3366 or the address shown above.

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:

_____
_____

☐ 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:

_____
_____

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

_____
_____

Signature: _____ **Date:** _____
(Person Granting Authorization)

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

Personal Representative's Name: _____
(Please Print)

Description of Personal Representative Authority: _____

PLEASE RETAIN A COPY OF THIS REQUEST FOR CONFIDENTIAL COMMUNICATIONS FOR YOUR RECORDS

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