

Request for Confidential Transmission of Protected Health Information (PHI)



Complete the following chart with information about the person whose PHI is subject to this request.

Name (Last, First, MI):	
Address (City,State,Zip):	
Phone:	
Date of Birth:	

If you are not the employee, complete the following:

Employee Name:	
Employee ID #:	
Employee Date of Birth:	

I am requesting that the following PHI be transmitted to me by the alternative means or to the alternative location described below. (Specify if you are making this request because the Plan's current method of disclosure of PHI may endanger you.)

If I am a personal representative, I certify and attest that I am the duly authorized representative of the person whose health information is subject to this request. (A personal representative may be requested to provide verification of representative status.)

Signature of applicant or personal representative Date

Relationship of personal representative to member: _____

Send completed form to:

Privacy Official
Human Resources
7575 E. Main Street
Scottsdale, AZ 85251

Phone: (480) 312-7600
FAX: (480) 312-7960

Request approved

Request denied Reason for denial _____

By: _____
COS Signature Date Name and Title