



# Request for Confidential Communications of Protected Health Information

Description: This form is used to request delivery of communications about protected health information to an alternative location or through alternative means.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 gives you the right to request that Travis County communicate your protected health information to an alternative location and by an alternative means (for example, by email, fax, or text message).

In order for Travis County to accommodate your request, you must complete and submit the form to:

Privacy Officer  
700 Lavaca, Suite 1500  
Austin, Texas 78701

You may also email a scanned form to:  
[privacy@traviscountytexas.gov](mailto:privacy@traviscountytexas.gov)

**Please do not use this form if you only wish to alert Travis County of a change of address.**

## **Part I: Requestor's Information**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address on Record: \_\_\_\_\_  
Street City State Zip Code

Telephone Number on Record: \_\_\_\_\_ Email Address on Record: \_\_\_\_\_

If you are requesting confidential communications on someone else's behalf, provide the name and address of the person on whose behalf you are requesting and describe and provide proof\* of your legal relationship with the individual. Recognized legal relationships include: parent of minor child, legal guardian, power of attorney, or executor.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Relationship to the individual: \_\_\_\_\_

*\*Travis County will accept documentation such as a Power of Attorney or court order. You must also furnish a valid government issued picture ID.*

## **Part II: Request**

1. I request that Travis County only communicate with me regarding my protected health information using the following method(s):
  - Email (If selected, please provide your email address here) \_\_\_\_\_
  - Fax (If selected, please provide your fax number here) \_\_\_\_\_
  - Text Message (If selected, please provide your cell phone number here) \_\_\_\_\_

Mail (If selected, please provide the alternative address here) \_\_\_\_\_

Phone (If selected, please provide the alternative phone number here) \_\_\_\_\_

Other (Possible methods include courier or overnight express delivery): \_\_\_\_\_

2. If you checked more than one box above, please indicate which method you would prefer Travis County use when communicating with you. For instance, if you checked both email and fax, which method should Travis County use first?

My preferred or first choice is: \_\_\_\_\_

3. In the event that a communication cannot be sent to you using your preferred method, how should Travis County communicate with you? \_\_\_\_\_

4. Travis County must notify you of its approval or denial of your request. Please provide the mailing or fax address that Travis County can communicate with you regarding your request.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. In the space below, please tell us if you are requesting alternative communications because the location or method by which Travis County currently discloses your protected health information could endanger you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. The costs associated with certain requests may be passed on to the requestor (i.e. you). Where applicable, such costs will be paid for by me, in advance, by the following method:

- Cash
- Check
- Debit/Credit Card
- Other: \_\_\_\_\_

### **Part III: Acknowledgement**

By signing this form, I am confirming my request for alternative communications of my protected health information to the location and in the manners described above. **I understand this request applies only to communications about the individual named herein and that this request will remain in effect until Travis County is notified that you wish to modify or terminate it.**

\_\_\_\_\_  
Signature of Requestor

\_\_\_\_\_  
Date (Month/Day/Year)

**FOR OFFICE USE ONLY**

Date Received: _____ Received by: _____ Title _____	
Verification of Requestor's Identity: <input type="checkbox"/> Photo ID <input type="checkbox"/> Identifying Information <input type="checkbox"/> Matching Signature <input type="checkbox"/> Other: _____	If the request was submitted by a Personal Representative, the authority of the Personal Representative was verified by: <input type="checkbox"/> Executed Will <input type="checkbox"/> Documentation of Power of Attorney <input type="checkbox"/> Signed Authorization by the Individual <input type="checkbox"/> Other: _____
Action Taken: <input type="checkbox"/> Granted <input type="checkbox"/> Denied	If the request was denied, the reason for denial was: _____ _____
Date Requestor was Notified: _____	
Name and title of person who notified Requestor: _____	