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