



Request for Confidential Communications Policy

January 5, 2026

SCOPE

This policy applies to Florida Atlantic University's Covered Components and those working on behalf of the Covered Components (collectively "FAU") for purposes of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

POLICY

To allow individuals the opportunity to request communications from FAU by alternative means or at alternative locations through a "Confidential Communications Request" Form in accordance with the HIPAA Privacy Rule.

REASON FOR POLICY

To establish a procedure by which individuals may request confidential communications from FAU.

DEFINITIONS- Refer to Glossary and Terms

PROCEDURE

1. Individuals have the right to request to receive communications from FAU by alternative means or at alternative locations through a "Confidential Communications Request" Form. For example, individuals may ask that appointment reminder calls be made to them only at work rather than at home. All reasonable requests should be accommodated.
2. FAU will not inquire why the individual is requesting communications on a confidential or restricted basis.
3. All reasonable requests are expected to be accommodated. If a request cannot be reasonably accommodated or if there are any questions or concerns with a particular request, the Chief Compliance Officer shall contact the individual in writing or by telephone to explain why the request cannot be accommodated.
4. All confidential communication requests that are approved must be documented. Before communicating with any individual, an FAU workforce member should determine whether a confidential communication or other restriction exists.



CONFIDENTIAL COMMUNICATIONS REQUEST FORM

You have the right to receive confidential communications from request that Florida Atlantic University ("FAU") in a different way or at a different location. To request an alternative method of communications, complete this form, and submit it to the FAU facility or practice where you were treated. All reasonable requests will be accommodated within FAU's capabilities.

If you wish to be contacted at an address or phone number other than your home address or home telephone, please provide the following information:

Patient Name: _____ Date: _____

Address: _____ Phone: _____

This is a ___ New Request ___ Change to Prior Request ___ Withdrawal of Prior Request

Information for which confidential communications is requested (ie. billing, treatment):

___ All Communications ___ Only Billing ___ Only Treatment and Medical Records

Address to receive communications:

Telephone number to receive communications: _____

Please describe in as much detail as possible any other alternative means you request FAU use in communicating with you or any other alternative location not detailed above.

Print Name: _____ Date: _____

Signature: _____

If Authorized Legal Representative, relationship to patient: _____

FOR FAU USE ONLY:

Date Received: _____

Request Approved ☐ Denied ☐ If denied, reason: _____

Patient notified by: ☐ Telephone ☐ Letter Date: _____

Clinic representative: _____

Signature: _____ Date: _____