



COMMUNICATION ACCOMMODATION REQUEST FORM

**THIS FORM IS TO BE USED TO FILE AN OFFICIAL REQUEST FOR CHANGE IN ROUTINE
COMMUNICATION OF PROTECTED HEALTH INFORMATION.**

PATIENT IDENTIFICATION

Name: _____ Date of Birth: _____ SSN: _____
Address: _____ Phone: _____

REQUEST FOR ALTERNATIVE COMMUNICATION

I understand I have the right to request to receive communications of protected health information (PHI) from UCF Health Services by alternative means or at an alternative location. I understand that UCF Health Services will make every reasonable effort to accommodate this request.

Pursuant to that right, I hereby request that communication regarding PHI is provided to me, other than verbally and in person to me, be provided by sending the material to: _____ or in the following alternative manner: _____.

RIGHT OF DENIAL

I understand that UCF Health Services has the right to deny my request for communication accommodation to the extent allowed by law.

Patient Signature

Date

*Gina Shahbandar, Privacy Compliance Officer or Betty Calton, Patient Advocate
P.O. Box 163333, Orlando, FL 32816-3333 • (407) 823-2093*