Request for Alternate Means of Communication of Confidential Medical Information

I, _____ hereby request that confidential communications about my medical information or my medical records from the Arkansas Immunization Information System at the Arkansas Department of Health be communicated to me using an alternate means or be delivered to me using an alternate location. Under federal law 104-191, also known as HIPAA, I am entitled to request such an arrangement upon written request.

I request that confidential communications be:

___ Sent to an alternate address

Alternate Address: _____

_____

_____

_____

___ Sent via an alternate medium, such as Fax or Registered Mail:

Describe: _____

_____

_____

Policies and Limitations on Alternate Means of Communication

- ❑ Under federal law, we are required to accommodate "reasonable" requests for communicating confidential medical to you via alternate means. We may deny your request if we determine that your request is unreasonable.
- ❑ If an expense is involved in fulfilling your request, we may charge the expense back to you, plus a small service fee. If the expense involved is unreasonable or burdensome, we may deny your request on that basis alone.
- ❑ With your request, you agree that the security and confidentiality of your confidential medical information that we send to an alternate address or via an alternate means is your responsibility alone. If we act on your request and send communications as you have specifically directed us to do in writing, you agree that we cannot and shall

not be responsible for any inadvertent disclosures that may occur as a result of fulfilling your written request.

- ❑ You must accompany this request with a copy of a valid, government issued, photo identification document.

Patient Name: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Please complete all three pages. Photo ID is required

ARKANSAS DEPARTMENT OF HEALTH – IMMUNIZATION SECTION

In order for the Immunization Section staff to accurately search for records, please complete the information below. **Note there is space for up to three individual requests.**

PLEASE PRINT

Name of Patient whose record is being requested. First, Middle, and Last Name	
Male or Female	
Date of Birth (mm/dd/yyyy)	

PLEASE PRINT

Name of Patient whose record is being requested. First, Middle, and Last Name	
Male or Female	
Date of Birth (mm/dd/yyyy)	

PLEASE PRINT

Name of Patient whose record is being requested. First, Middle, and Last Name	
Male or Female	
Date of Birth (mm/dd/yyyy)	

Return by email to immunization.section@arkansas.gov or you may reply by fax to:

FAX #501-661-2300 ATTN: Immunization Records Request

Or you may reply by regular mail to:

Arkansas Department of Health
4815 West Markham Street Slot #48
ATTN: Immunization Records Request
Little Rock AR 72205-3867