

**Request for Alternate Means of Communication  
of Confidential Medical Information**

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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

Arkansas Immunization Information System

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: \_\_\_\_\_

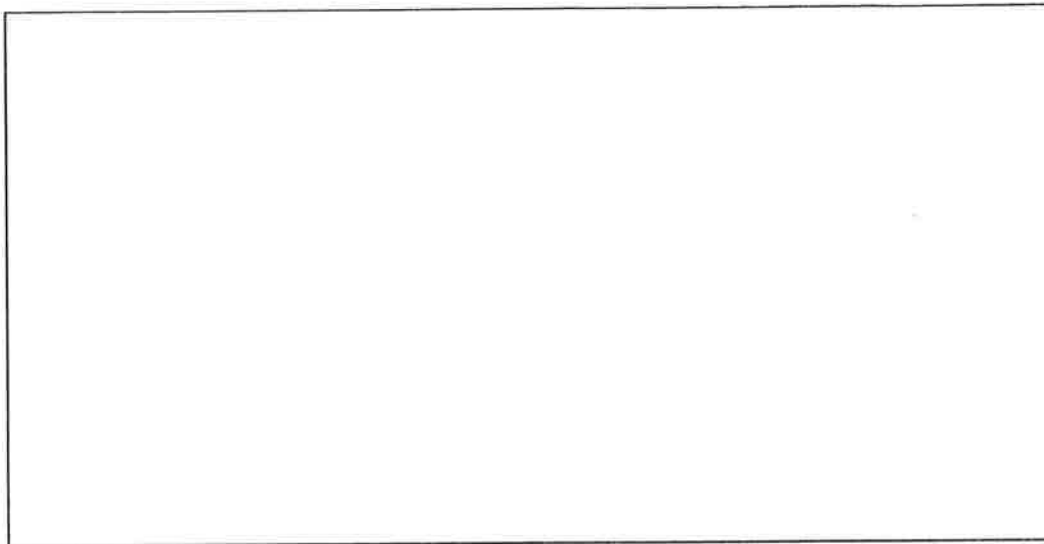
\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
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)	

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Male or Female	
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Male or Female	
Date of Birth (mm/dd/yyyy)	

Return by email to [immunization.section@arkansas.gov](mailto: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:

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