FERRIS STATE UNIVERSITY
HUMAN RESOURCES

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Part I: To Be Completed By Health Plan Participant; Employee, Spouse, or Dependent

1. Please complete the following:

Employee Name: _____

Employee's Department: _____

Health Plan Participants Name: _____

Participant Relationship: ☐Employee ☐pouse ☐ependent ☐☐A

Address: _____

Phone number: _____

E-mail address: _____

Social Security #: _____ Date of birth: _____

2. I, _____, request that all of my protected health information be communicated in the following manner (please check all that apply):

☐ Fax
Fax number: _____

☐ Telephone
Phone number: _____

☐ Mail
Address:_____

_____

☐ E-Mail
Address:_____

_____

☐ Other: _____

3. Check if applicable

☐ I hereby certify that failure to disclose all or part of my protected health information as requested above could put me in danger.

☐ I hereby certify that failure to disclose all or part of my protected health information as requested above could put the individual for whom I am responsible in danger.

4. By signing this document, I hereby warrant that I have truthfully represented my identify and that I am authorized to make this request. I understand that if I have misrepresented my identity or my authority, that Ferris State University may seek whatever criminal and civil relief is available.

Participant Signature*: _____ Date: _____

*Dependents under age 18 require a parent or legal guardian's signature

5. Submit this form to the Privacy Officer (PRK-150).

420 Oak Street
Prakken 150
Big Rapids, MI 49307-2020

Phone: (231) 591-2150
Fax: (231) 591-2978
Web: www.ferris.edu

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Part II: To Be Completed By the Privacy Officer.

Received by: _____

Date received: _____

Status: Granted: _____ Denied: _____

Date processed (attached): _____

Request processed by: _____

Federal law requires the retention of this document and all documents concerning this matter for a period of six years, beginning on the date of the final disposition of this request.

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