HELIOS, STONERIVER PHARMACY SOLUTIONS, LLC, AND STONERIVER P2P LINK, LLC
REQUEST FOR CONFIDENTIAL COMMUNICATION
OF PROTECTED HEALTH INFORMATION

Person requesting confidential communication of protected health information:

Patient Name:	**Social Security No.**	
Date of Birth:	**Date of Injury:**	
Street Address:		
City:	**State:**	**Zip:**

Communications with the patient named above should be directed to:

Name:		
Street Address:		
City:	**State:**	**Zip:**
Telephone Number:		

If the request for confidential communication will prevent the entities named above from submitting claims to the patient's health plan or insurer, the request will be accommodated only if the patient identifies another method of paying for services provided by the medical practice. Please describe any payment arrangements :

NOTE TO AUTHORIZED REPRESENTATIVES: If an Authorized Representative is signing this form on behalf of the patient, additional documentation supporting the authorization to disclose patient information, such as a Power of Attorney for healthcare, must be submitted in order for records to be provided.

Signature of Patient or Authorized Representative:	**Date:**
Relationship of Personal Representative to Patient or Statement of Authority: (if applicable)	

SUBMIT THIS FORM TO ADDRESS BELOW, OR FAX TO 614-212-8008

HELIOS, Attn: Medical Records
250 Progressive Way
Westerville, OH 43082
Fax: (614) 212-8008