REQUEST TO USE ALTERNATIVE CONTACT INFORMATION

You have the right to request that Erie County use alternative methods of communication, or alternative locations to receive communications. Please refer to the Erie County Notice of Privacy Practices for a more detailed description of your rights. If you would like to request that we use an alternative method or location for communications, please complete and return this form to:

Erie County Chief Privacy Officer
95 Franklin Street, Room 1634
Buffalo, NY 14202
Chief.Privacy.Officer@erie.gov

CONTACT INFORMATION

PATIENT NAME: _____
(please print)

PHONE NO.: _____

DATE OF BIRTH: _____

MAILING ADDRESS: _____

EMAIL: _____ DATE OF REQUEST: _____

DESCRIPTION OF REQUEST

1. Please indicate which of the following department(s) of Erie County you would like to use the alternative contact information provided herein:

- ☐ Department of Emergency Services
- ☐ Department of Health
- ☐ Department of Mental Health
- ☐ Other _____
- ☐ Department of Senior Services
- ☐ Department of Social Services
- ☐ Youth Services

2. Please describe your requested accommodation(s): below:

_____

_____

_____

3. Please write the address where we can send information (if different from above):

_____

_____

4. PREFERRED PHONE NUMBER

Please list phone number(s) and indicate whether we may call you at the number and/or leave a message.	(circle "Y" if okay) Okay to call?	Okay to leave message?
Home: _____	Y	Y
Work: _____	Y	Y
Cellular: _____	Y	Y
Other: _____	Y	Y

5. PREFERRED BILLING ARRANGEMENT

Please specify your preferred billing arrangement (if applicable) below:

_____

_____

SIGNATURE AND VERIFICATION

I have read, understand and had an opportunity to ask questions about this form. I further understand that under certain circumstances, Erie County may deny this request. I understand that Erie County may charge me a reasonable cost-based fee for expenses such as copying, mailing or staff time related to this request.

SIGNATURE: _____ DATE: _____

NAME AND ADDRESS OF PERSONAL REPRESENTATIVE (if applicable):

_____

_____

PERSONAL REPRESENTATIVE'S AUTHORITY (supporting documentation is required):

☐ Parent
☐ Health Care Agent
☐ Other: _____
☐ Court-Appointed Guardian
☐ Power of Attorney
☐ Administrator/Executor

VERIFICATION REQUIREMENTS

For in-person requests for an amendment of health information, patients and authorized representatives can meet verification requirements with one of the following:

☐ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request)
☐ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID *and* copy of appointing document (copy to be retained with request)

Notarization is required for requests submitted to Erie County by mail. An authorized representative must also submit a copy of the appointing document. The notary public or other officer authorized to take and certify acknowledgments and administer oaths must complete the following:

STATE OF NEW YORK

COUNTY OF _____

On the _____ day of _____ in the year _____ before me, the individual referenced above, personally appeared and proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this form and acknowledged to me that he or she executed the same in his or her capacity, and that by his or her signature(s) on the form, the individual executed the form.

_____
Notary Public

Printed Name: _____ My Commission Expires: _____

FOR ADMINISTRATIVE USE ONLY: Date Received: _____ Request has been: ☐ Accepted ☐ Denied
Staff member: _____ Title: _____

This information should be placed in a prominent location in the record to remind staff to use alternative addresses and/or phone numbers.