

Protected Health Information Communication Form

Please print

Office

Please fax to:

Your name: _____

Washington State 800-206-6910

Your phone: () _____

Oregon State 503-655-0778

Your address: _____

California State 877-252-7556

This request is related to the following individual(s): _____

I request the following restrictions or limitations on protected health information (Please use back if necessary. Please print): _____

I wish to request that CHOICE Advisory Services, Inc. change the manner which or location where communications are received. (Please use back if necessary. Please print): _____

I would like to request a copy of my protected health information.

I would like to request that my protected health information be amended as follows (Please use back if necessary. Please print): _____

I would like to request an accounting of disclosures of my protected health information for the following dates: _____ to _____.

I would like to request a paper copy of the written notice of Privacy Practices of CHOICE Advisory Services, Inc.

Your signature (required): _____

Please Send to: CHOICE Advisory Services, Inc. PO Box 12494 Mill Creek, WA 98082-0494