[Insert Letterhead]

**Request for Communication Accommodation**

|  |  |
| --- | --- |
| Date: |  |
|  |  |
| Requestor’s Name |  |
| and Address: |  |
|  |  |
|  |  |
| Telephone Number: |  |
|  |  |
| Date of Birth: |  |
|  |  |
| Medical Record Number: |  |

|  |  |
| --- | --- |
| Requested Communication Accommodation: |  |
|  |  |
|  |  |

I understand that this request may not be accepted and that I will be notified of the decision to accept or deny this request.

Signature of patient or personal representative (and relationship of personal representative)

For [Insert Covered Entity name]’s Use Only

Date Request for Accommodation Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deadline to Respond: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (30 days after request received)

Date Acknowledgment Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acceptance: \_\_\_\_\_\_\_\_\_\_\_

Denial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Privacy Officer/Designee Date