Request for Confidential Communications

Patient Information			
Last Name	First Name		Patient ID #
Street Address			Date of Birth / /
City	State	Zip Code	Phone Number ( )

You have the right to request how and where we contact you about your medical and billing information. We will accommodate reasonable requests if you provide a reasonable alternative means or location for communicating with you. Once the form has been reviewed we will let you know of our decision. **Please mail the completed and signed form to: Myriad Privacy Department, 320 Wakara Way, Salt Lake City, UT 84108.**

Please check the information you are requesting to be changed:	*New Contact Information to be Used:*
☐ Mailing Address	
☐ Billing/Guarantor Address, if different	
☐ Telephone	
☐ Other *(please specify)*	
Additional instructions:	

**Myriad does not routinely use email or fax to communicate with patients.*

I understand that this request will not be communicated to or affect my communication preferences with other organizations outside of Myriad and its subsidiaries.

Patient or Personal Representative Signature	Date
Print Personal Representative Name *(please attach applicable legal documentation)*	Relationship to Patient

TO BE COMPLETED BY MYRIAD	
Date request received:	Reason for denial:
☐ Request accepted ☐ Request denied	
Date notification sent to patient or personal representative:	☐ Requested information updated in applicable systems
Representative name/signature	Date