IOWA Health and Human Services

Request to Change How Health Information Is Provided

Name of Client	Date of Request
Mailing Address – Street or P.O. Box	State ID

City, State, and Zip Code	Phone Number	Date of Birth

Email Address	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone

Check all the programs that apply:

☐ Medicaid ☐ Hawki ☐ Woodward Resource Center

☐ Cherokee Mental Health Institute ☐ Independence Mental Health Institute

To be completed by the client or client's personal representative

I request that the following health information currently being given to me by the Iowa Department of Health and Human Services (Department) be given to me in a different way or in a different place.

I understand that the Department is not required to agree to my request if it is not reasonable.

I understand that if my request involves issues about payment for my health care, the Department will need to know how payment for services will be made before it will agree to my request.

I understand that if my request is approved, that means a different address for me must be entered into the Department computer system. All of the things that the Department mails to me through that system must go to that different address. This will include FIP or PROMISE JOBS cards, Medicaid cards, Food Assistance EBT cards, all Notices of Decision about eligibility and benefits, and other Department mailings.

If I disagree with the Department decision, I may file an appeal with the Department following the directions provided to me in the decision documentation.

I would like the following health information to be shared differently: _____

_____

I want this information shared differently because: _____

_____

Check the box that tells how you want this information to be shared and complete the blank:

☐ Mail this information to the following address: _____

☐ Give this information to the following person to share with me: _____

☐ Other: _____

_____

Client or Personal Representative Signature	Date
Representative Printed Name	Relationship to Client

To be completed by Privacy Officer	
☐ Request is granted. Should the Department need to stop honoring your request to change how information is provided, we will send you a written notice. ☐ Request is denied. Reason for denial: _____	
Manual and Rule Reference:	
Privacy Officer Signature	Date