REQUEST FOR CONFIDENTIAL COMMUNCATIONS BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS

Patient's Name: _____

Date of Birth: _____

You may request to receive confidential communications of Protected Health Information by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

If you make a special request, you must give us an alternative address or other method of contacting you (phone number, email address, etc.) Please specify how or where you wish to be contacted:

_____

_____

_____

_____

Patient or Legal Representative

_____

Date