Request for Communication by Alternate Means

Patient Name: Date of Birth: Patient Record #

Address City State Zip Code

I request an alternative means of communication of my health record information or communication of my health information to an alternate location.

I understand that the request for communication by alternative means or to an alternate location is applicable only to information held by our practice and disclosure by alternative means may not be protected and could endanger me. I understand that request for fax communication may be intercepted by others and our practice is not responsible if such intercepts occur.

Please Note: We are not able to accept e-mail addresses as an alternative means of communication at this time.

☐	Alternate Mailing Address:	
☐	Alternate Phone Number:	
☐	Other Alternate Method:	

This request applies to the following information:

☐	Today's Date of Service Only			
☐	From Date:		To Date:	
☐	From Date:		Until Further Notice	

Signature of Patient or Personal Representative Date

For Office Use Only

Date Received ☐ Request is approved. ☐ Request is denied.

If denied, reason for denial must be listed.

Reason for denial

Comments of Healthcare provider

Signature of Healthcare provider reviewing this request

Date:

Submit by Email Print Form