_____

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Please use this form to request that _____ communicate with you by alternative means.

Today's Date: __/__/_____

Patient Name:
Birthdate:
Address (address, city, state, zip code):
Phone:
E-Mail Address:
PREFERRED ALTERNATIVE COMMUNICATION: ALTERNATIVE ADDRESS OR CONTACT INFORMATION:
Signature of Patient or Personal Representative: _____
Date: _____
Name of Personal Representative: _____ Relationship to Patient: _____
(I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.)
Please return this form to: _____ _____ _____
FOR OFFICE USE ONLY: Date Received: _____ Date Updated: _____
Updated By: _____