

# Essence of Pure Living

www.wholisticthermography.com

## REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Request: \_\_\_\_\_

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

**Mailing Address.**

If appropriate, please contact me at the following address:

\_\_\_\_\_

**Phone.**

If appropriate, please contact me by telephone at the following number:

\_\_\_\_\_

**Fax.**

If appropriate, please contact me by fax at the following number:

\_\_\_\_\_

**E-Mail.**

If appropriate, please contact me by E-mail at the following E-mail address:

\_\_\_\_\_

**I have the following additional requests for confidential communications regarding my Protected Health Information:  
(Please explain)**

\_\_\_\_\_  
\_\_\_\_\_

**I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.**

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

Accepted as requested. \_\_\_\_\_

Modified as noted: \_\_\_\_\_

\_\_\_\_\_

Authorized Signature of Facility

\_\_\_\_\_

Date