

REQUEST FOR ALTERNATIVE COMMUNICATIONS
BRANT L. GERCKENS D.C.

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