



Request for Alternative Means for Communication of Health Information

Member Name: _____ Date of Birth: _____

Medical Record #: _____

Member Address: _____

Number where you can be reached: _____

I hereby request that any future communications to me from Alliance Health regarding my health information be directed through alternate methods or means as follows:

Alternative Phone Number: () _____

Alternative Mailing Address: _____

Other Alternative Means: _____

Member/Legally Responsible Person

Date

This Section for Agency Use Only

Request APPROVED

Agency Requirements:

- Documentation of request approval
- Notification to staff of alternative communication method(s)
- Notification to Business Associates, as needed

Request DENIED

Reason for Denial:

- Too expensive to accommodate request
- Administratively impractical to accommodate request
- Failure of Client to specify an alternative accommodation

Alliance Staff Signature

Title

Date

Once completed, scan and save form to Patient-> Demographics->Consents.