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

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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.