REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient name _____ Date of birth _____

Patient number _____ Telephone _____

Please direct communications of my protected health information to me as follows:

Means of communication:_____

_____

_____

_____

Location of communication:_____

_____

_____

_____

I understand that Generations Family Practice may refuse to accommodate my request if it is not reasonable. I also understand that Generations Family Practice can condition its accommodation of my request on obtaining the following information from me:

Generations Family Practice's Conditions (complete as appropriate):

_____

_____

How payment will be handled: _____

_____

Alternate address or method of contact: _____

_____

_____ _____

Signature of Patient or Authorized Party Date

_____

Printed Name

_____

Relationship to Patient