HIPPA CONTACT FORM
REQUEST FOR CONFIDENTIAL COMMUNICATION BY
ALTERNATIVE MEANS OR ALTERNATE LOCATION

I, ______________________________, Date of Birth____________ authorize/request an alternative means of communication of my health information (e.g., regular mail, telephone, facsimile) or communication of my health information to an alternate location.

I understand that request for communication by alternative means or to an alternate location is applicable only to information held by Health Back Center and disclosure by alternative means may not be protected and could endanger me. I understand that request for alternative means of communication may be intercepted by others and Health Back Center is not responsible if such intercepts occur.

Please indicate in detail your authorized alternative means or alternate location for receiving communications from Health Back Center.

☐ Email Reminders: ______________________________

☐ Phone Call Reminders: ______________________________

☐ Permission to leave message on voicemail/recorder: ☐ Yes ☐ No

☐ Alternate Mailing Address:

______________________________ __________ __________

☐ Use mailing address provided on initial paperwork or by written update.

☐ Alternate Phone Number

☐ Alternate Means of Contact (Please specify):

This request applies to the following information: ☐ Today's Date of service only
☐ From:__________ ☐ To:__________
☐ From:__________ Until Further Notice

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (If Personal Representative, state relationship to patient)	DATE
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark)	DATE

FOR HBC USE ONLY

☐ Request Approved ☐ Denied
If denied, reason (check one):
☐ Request is not reasonable to accommodate ☐ Alternate address or contact not provided
☐ Failure to provide information on how payment will be made (if applicable)
☐ Other (please explain):______________________________