

McLaren Macomb
CONFIDENTIAL COMMUNICATIONS

I request that all communications to me of my protected health information be sent or made to me at the alternative means or alternative locations, as follows:

Alternative address: _____

Alternative telephone: _____

I authorize the practice of leaving a message on my answering machine/voice mail: Yes No

FOR APPOINTMENT REMINDERS ONLY:

1) Use cell phone: Yes _____ No

2) Use e-mail: Yes _____ No

I authorize the release of my protected health information over the telephone to the following individuals:

Name of person: _____ Relationship: _____

Phone number: Home _____ Work _____

Name of person: _____ Relationship: _____

Phone number: Home _____ Work _____

Name of person: _____ Relationship: _____

Phone number: Home _____ Work _____

Patient Signature: _____ Date: ____ / ____ / ____

Witness Signature: _____ Date: ____ / ____ / ____

FOR OFFICE USE ONLY:

Agrees to patient's request for confidential communications

Does not agree to patient's request for confidential communications.

Comments: _____

Signature: _____ Date: ____ / ____ / ____

CONFIDENTIAL COMMUNICATIONS

MO-152 (9/14)

Patient Name:

Date of Birth: