	Protected Health Information Alternative Communications Request Form	**Revision Number: 001**

Patient to complete the following information:

Patient Name: ____

Date: ____

Request

I wish to receive communication of my Protected Health Information from the Facility by the following means:

____

____

____

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Protected Health Information Alternative Communications Request Form

Facility to complete the following

Date the request was received: ____

Alternative communication has been:

- ☐Accepted
- ☐Declined: The request is not reasonable because:

____

____

____

Completed by	
Signature of Facility Representative	
Date	