REQUEST FOR ALTERNATIVE COMMUNICATIONS

Date Of Request: _____

Patient's Name: _____

Patient Address: _____

Dental Record Number: _____

Alternative Location or Address For Your Communications:

_____

_____

_____

_____

Alternative Method Of Communication:

_____

_____

How Payment Will Be Handled:

_____

_____

_____ _____

Signature of Patient or Personal Representative Date

_____

Personal Representative's Authority

For Office Use Only:

Date Received: _____

Date Patient Notified: _____

Request Granted: ___ No __Yes, Reason:

_____

Changes noted in the patient record and computer files: __ No __Yes

Name of Privacy Officer: Dr. Hien T. Nguyen