Communication Preferences
Request for Alternative Means of Communication of Protected Health Information

From time to time, it may be necessary and/or desirable to contact you regarding your appointment or health care. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. If you choose to be contacted by another method or no notification at all, please use this area to **let us know your preferences**.

My current contact information is:

Name:	DOB:
Address:	
Phone Number(s):	

_____ (initials) I authorize Specialists in Women's Care to leave detailed and confidential information about my health care using this contact information.

The remainder of this form is OPTIONAL.

Complete the remaining sections if you would like to be contacted at a different phone number and/or address. You should also complete this form if you would like to authorize this office to communicate with someone else regarding your medical care.

I request that any future communications to me regarding my health information be directed through alternate methods or means as follows. Specialists in Women's Care is unable to accept an e-mail address as an alternative means of communication at this time:

Alternate Phone Number(s):
Alternate Mailing Address:
Other (please be very specific):

☐ **I authorize Specialists in Women's Care to speak to the following person(s) regarding my medical care:**

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

I understand that this request is only applicable to information held by Specialists in Women's Care, PC. I also understand that the use of an alternative means of communication may not be protected and could endanger my privacy. I understand that requests for FAX communication may be intercepted by others and Specialists in Women's Care, PC is not responsible if such intercepts occur. I understand that I may change this consent, in writing, at any time. By signing this form, I am consenting to the use and disclosure of my protected health information by Specialists in Women's Care, PC.

_____ _____

Signature of patient, parent or legal guardian Date of Request