St. Elizabeth PHYSICIANS

Receipt of Notice of Privacy Practices
ALTERNATE COMMUNICATION REQUEST FORM

Patient Name ____Date of Birth _____/_____/_______
(Print full name)

I wish to be contacted in the following manner (check all that apply):

☐ By home, cell or work phone listed in my registration as below.

Home	Cell	Work		Other ______________________________
☐	☐	☐	O.K. to leave message on voice mail	______________________________
☐	☐	☐	O.K. to leave message with individual	______________________________
☐	☐	☐	Leave message with call-back number only	______________________________
☐	☐	☐	Do not leave message	______________________________

☐ Written Communication

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office address

☐ O.K. to mail text me

☐ O.K. to fax to this number ______________________

☐ O.K. to e-mail to address listed in my registration

I, ______________________________ give permission to the following individuals to obtain the indicated information:
(Name of Patient or Responsible Party)

__________________________ whose relation to me is ________ _____ _Phone (____)_____-________
(Name of person) (Relationship to Patient)

__________________________ whose relation to me is _______________Phone (____)_____-________
(Name of person) (Relationship to Patient)

__________________________ whose relation to me is _______________Phone (____)_____-________
(Name of person) (Relationship to Patient)

__________________________ whose relation to me is _______________Phone (____)_____-________
(Name of person) (Relationship to Patient)

______ Prescription refills on my behalf

______ Test results on my behalf

______ Set up appointment/ or cancel on my behalf

______ Speak to the doctor/MA either in person or by telephone on my behalf

______ Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID.

Effective Date _________________Expires _________________Revoked __________

______ ***Please note:** This form does not apply to pregnancy, sexually transmitted diseases, contraception, chemical dependency/substance abuse, or psychiatric/psychological conditions.*
Initials

It is the responsibility of the patient to notify the physician's office if there is a change in this information.

*****Scan original in chart, copy may be given to patient*****

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*By signing this waiver I release St. Elizabeth Physicians and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of St. Elizabeth Physicians **Notice of Privacy Practices**. The effective date of the notice is:* ___09/23/13_____

Signature of patient or responsible person ____

Relationship of Representative to Patient ________________________________ Date ____________

Signature of witness ____Date __________________