Request For Alternative Communications

Patient Name: _____Email_____

Address:_____City/State/Zip:_____

Date of Birth:_____ Date of Request:_____

As allowed by the Privacy Regulations, I wish for Mindful Solutions Thermal Imaging to provide the following "Alternative" means of communicating my Protected Health Information by the following means. **Check all that apply**:

- **Mailing Address**. Please contact me at the following address:

  _____

- **Fax**. Please contact me by fax at the following number:

  _____

- **Phone**. Please contact me by phone at the following number:

  _____

- **Email**. Please contact me by the following email address/addresses:

  _____

- I have the following requests for confidential communication regarding my Protected Health Information: (Please explain)

  _____

  _____

I understand that there may be additional costs associated with this request and I agree to reimburse this office with such costs.

_____ _____

Signature Date

_____ _____

Authorized Signature of Facility Date