Memorial Healthcare

Request for Alternative Method of Communication

Patient name (print):_____D.O.B_____

Medical record #: _____Account#:_____

Mailing address: _____

I am requesting that the Hospital communicate with me by alternative means or at alternative locations for reasons of confidentiality (e.g., at an address other than my home address, by envelope rather than by postcard, at my office telephone instead of my home telephone).

Tell us the alternative method or location you are requesting: _____

_____

_____

I understand that the Hospital will comply with reasonable requests and will inform me of its response. If the Hospital agrees to the above change, it will affect only communications occurring after the acceptance date.

I agree that this change will not affect my payment responsibility or processes necessary to obtain payment for Hospital services.

I understand that I may terminate or change this request by notifying the Hospital in writing.

_____ _____

Patient Name (Please Print) **Date**

_____ _____

Signature of Patient or Legal Representative **Date**

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Submit Form To:
Director of Health Information Management
Memorial Healthcare / 826 W. King St. / Owosso, MI 48867

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Hospital use only:

Patient notified date: _____

Request has been: *( ) Accepted* *( ) Denied*

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Scan this form in the correspondence section of the Medical Record when complete