REQUEST FOR ALTERNATIVE COMMUNICATIONS
The Speech Pathology Center of Louisiana, LLC

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As allowed by the Privacy Regulations, I wish this office to provide the following "Alternative" means of communicating my Protected Health Information:

☐ **Mailing Address**.
If appropriate, please contact me at the following address:
_____

☐ **Phone.**
If appropriate, please contact me by telephone at the following number:
_____

☐ **Fax.**
If appropriate, please contact me by fax at the following number:
_____

☐ **E-Mail.**
If appropriate, please contact me by E-mail at the following E-mail address:
_____

☐ I have the following additional requests for confidential communications 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 for such costs.

_____ _____
Signature Date

☐ Accepted as requested. ☐ Modified as noted: _____

_____ _____
Authorized Signature of Facility Date