

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Notice to all patients: Please use this form to make a request to Oakview Internal Medicine, P.C. that we communicate with you by an alternative means. As the patient, you understand that our clinic will make all reasonable efforts to accommodate this request.

In order for Oakview Internal Medicine, P.C. to respond promptly and accurately to this request. Please complete the form in its entirety.

Proposed Alternative Communications

Please complete all sections which apply to you.

_____ Please do not contact me at my home phone - use this number _____

_____ Please do not contact me at the work phone - use this number _____

_____ Please send all mail to this alternative address _____

_____ Please do not leave messages on the answering machine.

_____ My Protected Health Information(PHI) may be released and discussed with _____

Patient Information:

Patient Name: _____

Date of Birth: _____

I understand that in some emergency situations, my protected health information(PHI) may be released.

Signature: _____ **Date:** _____

Relationship to patient if applicable: _____

You may contact our Practice's Privacy Official if you have questions relating to this request form.

Oakview Internal Medicine, P.C.
2727 S. 144th Street Suite 100
Omaha, Ne 68144
402-778-5600
Privacy Officer: Jill K.