



Request for Confidential Communications

Date of Request: _____

Patient/Individual

First Name

Middle Initial

Last Name

Date of Birth

Phone Number (with area code)

Email Address (optional)

Requestor (if different from Patient/Individual)

Note: Written permission/documentation must be on file for a party to make a request on the patient's behalf.

First Name

Last Name

Relationship to Patient

Phone Number

Email Address (optional)

Request for Communications by Alternate Means

I request that Rocky Mountain Senior Care communicate with me by alternative means or at alternative locations for reasons of confidentiality. I understand that Rocky Mountain Senior Care will comply with reasonable request and will inform me directly and in writing if they are unable to comply with my request. Rocky Mountain Senior Care will not ask for any reason for this request.

Please describe the request:

Review and Sign

I understand that if correspondence sent to an alternate address is returned undeliverable, if the alternate phone is disconnected/out of service, or if I fail to respond in a timely manner to communications via an alternative address/phone that I have provided, Rocky Mountain Senior Care will communicate with me via other means and/or at other locations.

Signature of Individual or Individual's Legally Authorized Representative

Date

X _____

Please send this completed form by mail or email to:

Attn: Privacy Officer
Physician Health Partners
PO Box 13406
Denver, CO 80202-9998

Privacy@Alpine-Physicians.com