



Patient Name:
Medical Record Number:

Date of Birth:

The Request for Alternative Communication form is intended for patients or legal guardians to request that the patient's protected health information (PHI) is communicated by alternative means or to an alternative location. This request must be made in writing.

Gillette Children's Specialty Healthcare must accommodate all reasonable requests, but may deny any unreasonable requests. Examples for denying a request may include not specifying the alternative address for the information to be sent, or requesting electronic transmission of information that is not currently stored electronically.

I, _____, request that the following protected health information:

- Test results
- Medical dictations
- Appointments
- Other (Specify): _____

be communicated by the following means:

- By phone to the following phone number: _____
- By mail to the following address: _____

- Email Communication (*will not be encrypted to or from Gillette*) _____
- Other (Specify): _____

Expiration Date or Event: _____

I understand that Gillette Children's Specialty Healthcare has the right to deny any unreasonable requests. I understand that if I do not completely fill out this form, Gillette Children's Specialty Healthcare may deny this request. I understand that if, at any time, I wish to revoke this request, I must fill out another of these forms to specify the correction. This request may take up to 60 days to take effect.

Signature: _____ Relationship to patient: _____ Date: _____