

Family Wellness Center, PC Requests for Confidential Communication of Protected Health Information

Name (First MI Last):	
DOB (Date of Birth):	
Address:	
Telephone Number:	
Date:	

I, _____, request that Family Wellness Center, PC provide communications regarding my protected health information to the following:

Alternative Method of Contact:	
- Name:	
- Address:	
- Relationship to Patient:	
- Home Phone # :	
- Cell Phone #:	
Alternative Facility / Location of Contact:	
- Name of Facility:	
- Address:	

I understand that this request to provide my protected health information to alternative contact or alternative location will be in effect until revoked in writing.

Individual's Signature

Date

For Family Wellness Center, office use only:

Request Approved By:	
Date Approved:	