Lake Podiatry, PA
144 Highland Street
Unit One
Plymouth, NH 03264

Patient's Request to Receive Confidential Communications by Alternative Means

Patient Name: _____ Patient ID#: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Work Phone: _____

As provided by Privacy Rule Section 164.522(b), I hereby request that Lake Podiatry, PA (the "Practice") make all communications to me by the alternative means that I have listed below.

□ Alternative Phone Number _____
□ Alternative Mailing Address _____
_____
□ Other _____

Mark all written communication to me as follows:

□ CONFIDENTIAL PROTECTED HEALTH INFORMATION

□ Other:_____
_____

I understand and acknowledge that:

1. This authorization is voluntary and I may refuse to agree to its terms without affecting any of my rights to receive healthcare at the Practice.

2. This Authorization may be revoked at any time by notifying the Practice in writing at the above address to the attention "Privacy Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until revoked or changed.

_____ _____

Name of Individual (Printed) Signature of Individual Date

Witness: _____