Alternate Communication Request Form

Patient Name: ____ Date of Birth:______________

___I wish to be contacted in the following manner (Check all that apply):

By home, cell, or work phone listed in my registration as below.

Home Cell Work Other: ________________________________

OK to leave message on voicemail ________________________________

OK to leave message with individual ________________________________

Leave message with call-back number only ________________________________

Do not leave message ________________________________

Written Communication

OK to mail to my home address

OK to mail to my work/office address

OK to text me

OK to fax to this number ___________________

OK to e-mail to address listed in my registration

I, _______________________________ give permission to the following individuals to obtain the indicated information.

(Name of Patient or Responsible Party)

__________________________ whose relation to me is ___________________. Phone: ________________

(Name of Person) (Relationship to Patient)

__________________________ whose relation to me is ___________________. Phone: ________________

(Name of Person) (Relationship to Patient)

__________________________ whose relation to me is ___________________. Phone: ________________

(Name of Person) (Relationship to Patient)

__________________________ whose relation to me is ___________________. Phone: ________________

(Name of Person) (Relationship to Patient)

Prescription refills on my behalf

Test results on my behalf

Set up appointments or cancel on my behalf

Speak to the Doctor/Medical Assistant either in person or by telephone on my behalf

Pick up prescriptions, doctor's orders, or other needs on my behalf with a photo ID

Effective Date: ____________________

_________ ***Please note: This form does not apply to pregnancy, sexually transmitted diseases, contraception, chemical dependency/substance abuse, or psychiatric/psychological conditions.***

(initials)

It is the responsibility of the patient to notify the physician's office if there is a change in this information.

By signing this waiver I release Kidney Associates of the TriState and its staff therein, from any liability for release of information pertaining to my medical care as designated above and I acknowledge that I have received a copy of Kidney Associates of the *TriState Notice of Privacy Practices*.

Signature of patient or responsible person: ____

Relationship of Representative to Patient: ______________________________ Date: ________________

Signature of Witness: ____ Date: ________________

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