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 Colorado Physician Partners communicate with me by alternative means or at alternative locations for reasons of confidentiality. I understand that Colorado Physician Partners will comply with reasonable request and will inform me directly and in writing if they are unable to comply with my request. Colorado Physician Partners 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, Colorado Physician Partners 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