HEART & FAMILY HEALTH INSTITUTE of Port St. Lucie

Confidential Communications

Alternative Methods/Locations

Account # _____
(office use only)

Patient Name _____
Last First Initial

Date of Birth _____

Emergency Contact: _____ Phone# _____

I hereby request that my Protected Healthcare Information (PHI) including clinical information (e.g., test results, patient instructions) billing information and other matters, be communicated to me as follows:

Please check the alternative locations where you want to receive confidential communications about your PHI:

☐ Mail ☐ Home phone _____ ☐ Fax _____
Phone # Fax #

☐ Leave message on home phone

☐ Leave message on cell phone _____
Cell Phone #

☐ Leave message on voice mail at work _____
Work Phone #

I understand that this request will apply to all future communications for all visits until changed by me by completing another form.

_____ _____
Signature of Patient/Guardian/Patient Representative Date

_____
Print Name of Patient's Representative