Receipt of Notice of Privacy Practices (Effective 11/17/2016)

ALTERNATE COMMUNICATION REQUEST FORM

Patient Name_____ Date of Birth_____/_____/_____
(Print full name)

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_____
☐	☐	☐	O.K. to leave message on voice mail	_____
☐	☐	☐	O.K. to leave message with individual	_____
☐	☐	☐	Leave message with call-back number only	_____
☐	☐	☐	Do not leave message	_____

☐ Written Communication

☐ O.K. to mail to my house address
☐ O.K. to mail to my work/office address
☐ O.K. to text me
☐ O.K. to fax to his number _____
☐ O.K. to e-mail to address listed on my registration

I, _____ give permission to the following individuals to obtain the
(Name of patient or responsible party)
indicated information:

_____ 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 appointment/cancel on my behalf
_____ Speak to Dr/MA/Office Staff 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

By signing this waiver I release Paradigm Pain and Spine Consultants 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 been offered/received a copy of the Notice of Privacy Practices. It is my responsibility to notify the physician's office if there are any changes to this information. ***Scan original in chart, copy may be given to patient***

Signature of patient or responsible party_____

Relationship of Representative to patient_____Date_____

Signature of witness _____Date_____