

Request for Confidential or Alternative Methods of Communication

You have the right to receive confidential communications from Carolinas HealthCare System (CHS) by an alternative method or at an alternative location. For example, you can ask that we only contact you at work or by mail. We will honor reasonable requests. We will also ask how payment will be handled and how you would like to be contacted to address payment issues.

To request an alternative method of communication, complete this form in its entirety, and submit it to the CHS Facility or Practice where you were treated. To find the address of the appropriate Facility or Practice, please go to www.carolinashealthcare.org and select "Location".

Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip Code: _____

I request Carolinas HealthCare System communicate with me (Check one and complete necessary information) as follows:

☐ By mail at: _____

(Please note this is the address CHS will use for all mailings to you. CHS is unable to administer more than one mailing address for a patient.)

☐ By telephone at: _____

☐ Other: _____

Tell us how we may contact you for payment: _____

I understand that requesting this alternative method of communication may interfere with CHS's ability to contact me in a medical emergency.

I understand and agree that, if I cannot be located by the alternative method requested, CHS may use any available contact information to locate me in the event that (1) CHS determines there is a medical emergency or similar situation in which my health is at risk if I am not contacted immediately; or (2) if I have not provided adequate information on how payments will be made.

Signature of Patient or Representative: _____ Date: _____

If signing as authorized representative, describe your authority to act for the patient, and submit documentation showing such authority, as appropriate: _____

For Carolinas HealthCare System Use Only

Alternative communication method has been: ____ Accepted ____ Denied

Signature(s): _____ Date: _____

Print Name & Title: _____

Comments: _____

Original: File or Scan in medical record.



Carolinas HealthCare System

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