Request for Confidential or Alternative Methods of Communication

You have the right to receive confidential communications from Atrium Health 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 Atrium Health or Practice where you were treated. To find the address of the appropriate Facility or Practice, please go to https://atriumhealth.org and select "Location".

Name: ____ Date of Birth: ____________________

Street Address: ____

City, State, Zip Code: ____

I request Atrium Health communicate with me (Check one and complete necessary information) as follows:

By mail at: ____

(Please note this is the address Atrium Health will use for all mailings to you. Atrium Health 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: ____

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

I understand and agree that, if I cannot be located by the alternative method requested, Atrium Health may use any available contact information to locate me in the event that (1) Atrium Health 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 Atrium Health Use Only

Alternative communication method has been: ____ Accepted ____ Denied

Signature(s): ____Date: ____________________

Print Name & Title: ____

Comments:____

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Original: File or Scan in medical record.

Patient Label

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