REQUEST FOR ALTERNATE COMMUNICATION OF PHI

Notice to Patient: Personal Best Health, LLC is not obligated to agree with your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient Name: ____________________________ Date of Birth: ____________________
Street: ____________________________ Apt #: ____________________
City: ____________________________
State: ____________________________ Zip Code: ____________________

Please indicate the restrictions or alternate means of communication that you are requesting from the practice:

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I am authorizing the following person(s) to be informed of my health condition(s), test results and any other information:

Individual's Name	*Relationship to Patient*
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________
__________________________	__________________________

__________________________ __________________________
Signature of Patient or Guardian Date

Request: ❑ Accepted ❑ Denied

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Privacy Officer