REQUEST FOR CONFIDENTIAL COMMUNICATION

I, _____ request communication of my protected health information by Westover Hills Orthopaedics by alternative means or at the alternative locations. I authorize Westover Hills Orthopaedics , and its assignees, including and not limited to its authorized agents, affiliates, and or contractors, to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone and employment telephone. I hereby grant permission and consent to Westover Hills Orthopaedics, and its assignees, including and not limited to its authorized agents, affiliates, and or contractors to place calls to my home telephone, cellular telephone, and employment telephone, leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or dialing devices in connection with any communication to me.

I wish to be contacted in the following manner: (check all that apply)
__Home Telephone _____ **__ OK to leave a message with details** **__ Leave a message with call back number only**
__Work Telephone _____ **__ OK to leave a message with details** **__ Leave a message with call back number only**
__Cellular Telephone _____ **__ OK to leave a message with details** **__Leave a message with call back number only**
Written Communication **__ OK to mail to my home address _____** **__ OK to mail to my work/office address _____**

As a service to our patients, we provide courtesy appointment reminder calls and other important calls that may be placed using an automated or prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

I wish for the following individuals to be allowed information verbally:

Name: _____Phone # _____ Relationship to Patient: _____

Name: _____Phone # _____ Relationship to Patient: _____

Name: _____Phone # _____ Relationship to Patient: _____

NOTE: This request will remain in effect until you notify us of a change

Patient Name Printed	**Patient DOB**	**Guardian Name Printed**
Patient Signature **Date Signed**	**Guardian Signature**	**Date Signed**

The identity of the requestor has been validated either with a picture ID, such as a driver's license or passport, or comparison of signatures documented in the medical record.