

ALTERNATE COMMUNICATION REQUEST FORM

Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth ____/____/____
(Please print full name)

I wish to be contacted in the following manner (check all that apply):

By the home cell or work phone listed on my registration form

Home Cell Work

- OK to leave a message on voicemail
- OK to leave a message with individual
- Leave a message with call-back number only

OK to text my cell (appointment reminders and other communication)

OK to send e-mail communication home work

OK to send mail to my home address

I give permission to the following individual(s) to obtain the indicated information on my behalf.

Name of person _____ Relationship _____ Phone ____ - ____ - _____

Name of person _____ Relationship _____ Phone ____ - ____ - _____

Name of person _____ Relationship _____ Phone ____ - ____ - _____

Set up or cancel appointments on my behalf Test results

Speak to the doctor/staff in person or by phone Refill/Pick up supplements

It is the responsibility of the patient to notify this office if there is a change in this information.

By signing this waiver, I release the doctor and staff therein from liability for release of information pertaining to my care as designated above. I further acknowledge that I have received a copy of the doctor's Notice of Privacy Practices (Effective date of the notice: 01/01/2010.)

Signature _____ Effective date ____/____/____

Terry L. Henderson, DC

Douglas P. Krift, DC

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