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 Philip A. Ryan IV, DC

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