THERMOGRAPHY IMAGING.COM

Fairfax Medical Center
10721 Main Street #204
Fairfax, VA 22030

703.270.1008
866.99.THERMO (84376)
info@ThermographyImaging.com
www.ThermographyImaging.com

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Patient Name:_____
Address: _____
Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

Mailing Address.
If appropriate, please contact me at the following address:
_____

Phone.
If appropriate, please contact me by telephone at the following number:
_____

Fax.
If appropriate, please contact me by fax at the following number:
_____

E-Mail.
If appropriate, please contact me by E-mail at the following E-mail address:
_____

I have the following additional requests for confidential communications regarding my Protected Health Information: (Please explain)

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

_____ _____
Signature Date

Accepted as requested. Modified as noted: _____

_____ _____
Authorized Signature of Facility Date