Request for a Specified Method of Preferred Communication

Patient Information

Last Name	*First*	*Middle*		*Request Made on: (mm/dd/yyyy)*
Street Address	*City*	*State*	*Zip*	*Birth Date: (mm/dd/yyyy)*
Patient's Personal Representative Name				*Patient's Phone #*

Request for Specified Alternative Confidential Communication Method

I hereby request that of communications containing my health information from Lamoille Health Partners be communicated in the following manner:

☐ At a telephone number other than my home. Preferred telephone number is: _____

☐ At a mailing address other than my home mailing address.
Preferred mailing address is: _____

☐ Other: Please specify: _____

☐ Requested expiration date: *(mm/dd/yyyy)*

Date: _____

Signature of Patient/Representative: _____

Printed Patient/Representative Name: _____

For Lamoille Health Partners Internal Use Only

Date request received: *(mm/dd/yyyy)*	☐ Accepted	☐ Global Alert Placed ☐ Demographics Updated

Signature of Lamoille Health Partners Representative: _____Date: ____/_____/_____