Hill Physicians
Your health. It's our mission.

Request for Alternative Communication
Health Insurance Portability and Accountability Act of 1996
45 CFR 160 §164.522(b)(1)

Hill Physicians Member Name: _____

Hill Physicians MR Number: _____

I request that Hill Physicians Medical Group, Inc. ("Hill Physicians") and any of its business associates who have or will have a need to communicate with the above named Hill Physicians member for any reason, do so in the following manner or to the following location:

1. If by mail, please forward any information to the following location:

   _____

   _____

   _____

   If the above address is to your personal representative, please indicate the nature of your acquaintance: _____.

2. If contact is made by telephone, please contact me or my representative at:
   _____

3. If contact is made by electronic mail, please contact me at: _____.

Yes ☐ **No** ☐ The request for an alternative method of communication between Hill Physicians and myself is made on the belief that disclosure of this information in the normal course of business may endanger my welfare.

I understand that Hill Physicians may not accept my request for an alternative method of communication if the request is unreasonable, as determined by Hill Physicians, or could not be easily accommodated in the normal course of business.

Dated: _____ By: _____
Signature

_____
Print your name

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HPMG Member's Name: _____

I am the authorized representative of _____. I am submitting this request for an alternative method of communication for and on behalf of the above HPMG member for the following reason: _____

_____

_____

_____

Dated:_____ By:_____
Signature

_____
Print your name

_____
Your Title