Hill Physicians

Alternative Communication Request

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

Please fill in

Individual's First and Last Name _____

Hill Physicians MR Number: _____

I request that Hill Physicians Medical Group, and any of its business associates, who has or will have a need to communicate with the above name Individual for any reason, to 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 Medical Group 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 reasonably accommodated in the normal course of business.

Dated _____ By: _____
Signature

_____
Print your name

—Form continued on back

Hill Physicians

Please fill in

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

_____

_____

_____

_____

Dated _____ By: _____
Signature

_____
Print your name

_____
Your Title

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Director, Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Director, Customer Service