SOUND PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
REQUEST FOR ALTERNATIVE COMMUNICATIONS FORM

PATIENT NAME: _____

BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: _____ EMAIL: _____

PLEASE RESTRICT COMMUNICATION OF THE FOLLOWING PROTECTED HEALTH INFORMATION ABOUT THE ABOVE PATIENT:

_____

_____

PLEASE COMMUNICATE THE PROTECTED HEAL TH INFORMATION DESCRIBED ABOVE **ONLY** AS FOLLOWS:

_____ _____
Signature of Patient **Date of Signature**

OR

_____ _____ _____
Signature of Guardian or Legally Authorized Representative (if patient is a minor or unable to sign) **Date of Signature** **Description of Authority to Act for the Individual**

_____
Printed Name of Legally Authorized Representative

Authorizations signed by a representative must contain a copy of the guardianship papers or power of attorney.

NOTE: *ALL REQUESTS FOR ALTERNATIVE COMMUNICATIONS MUST BE SUBMITTED IN WRITING ON THIS FORM. THE FORM SHOULD BE RETURNED TO THE PRIVACY OFFICER AT THE FOLLOWING ADDRESS:*

Chief Compliance & Privacy Officer
Sound Physicians
1498 Pacific Avenue, Suite 500 Tacoma, WA 98402
Phone: 1-855-768-6363
compliance@soundphysicians.com