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

PATIENT NAME:_____

BIRTH DATE:_____ SSN:_____

ADDRESS:_____

TELEPHONE:_____

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

_____

_____

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

ALTERNATIVE TELEPHONE NUMBER: _____

ALTERNATIVE ADDRESS: _____

OTHER ALTERNATIVE METHOD OF CONTACT: _____

_____

_____

CHOOSE METHOD OF PAYMENT FOR COSTS RELATING TO ALTERNATIVE COMMUNICATION: ☐ Bill me ☐ Check or Money Order

☐ Credit Card

If you are not the patient, please fill out the following information:

Name:_____

Relationship to Patient:_____

Address (if different from above):_____

Telephone (if different from above):_____

Please furnish a copy of any conservator/guardianship papers with this request.

SIGNATURE:_____ **DATE:**_____

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:*

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422

Internal Use Only:

REQUEST IS: _____ **APPROVED** _____ **DENIED**

SIGNATURE: _____ **DATE:** _____

TERMINATION OF AGREEMENT:
DATE TERMINATED: _____
SIGNATURE: _____