REQUEST FOR ALTERNATIVE COMMUNICATIONS

Center of Developmental Pediatrics

Patient Name:____

Address:____

Date of Birth:____________ **Date of Request:**_____________

As allowed by the "Privacy Regulations," I authorize Center of Developmental Pediatrics to provide the following "Alternative" means of communicating my Protected Health Information:

☐ **E-mail**

Please contact me at the following E-mail address:

____

☐ **Other**

I have the following additional requests for "Alternative" communication of my Protected Health Information: (please explain) ____

Signature of Patient/Patient Representative:

____