Family Wellness Center, PC
Requests for Confidential Communication of Protected Health Information

Name (First MI Last):	
DOB (Date of Birth):	
Address:	
Telephone Number:	
Date:	

I, _____, request that Family Wellness Center, PC provide communications regarding my protected health information to the following:

	Alternative Method of Contact:
	- Name:
	- Address:
	- Relationship to Patient:
	- Home Phone # :
	- Cell Phone #:
	Alternative Facility / Location of Contact:
	- Name of Facility:
	- Address:

I understand that this request to provide my protected health information to alternative contact or alternative location will be in effect until revoked in writing.

_____ _____

Individual's Signature **Date**

For Family Wellness Center, office use only:

Request Approved By:	
Date Approved:	