REVOKED by Patient/Authorized Representative

_____

Signature of Patient/Authorized Rep. Date

Rex Hospital, Inc. and Rex Physicians LLC

REQUEST FOR ALTERNATIVE MEANS OR LOCATION OF CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ MR #: _____

Street Address: _____ Date of Birth: ____/_____/_____

City: _____ State: _____ Zip Code: _____

Telephone: ( )_____ Last 4 digits SS# *(voluntary):* _____

I request an alternative means or location of confidential communications regarding my care from Rex Hospital, Inc. or Rex Physicians LLC ("Rex") as detailed below.

I authorize _____ to release protected health information regarding my care
(Name of Practice or Service Area)

in the following manner *(initial all you authorize):*

_____ I would like information left on my home voice mail. ***Phone Number***: _____

_____ I would like information left on my cell phone voice mail. ***Phone Number:*** _____

_____ I would like information left with my spouse. ***Name of Spouse:*** _____

_____ I would like information left with the following person. ***Name:*** _____

Relationship: _____

_____ I would like information shared with my Employer regarding FMLA/Disability.

_____ Other: _____

I would like the following information released in the manner detailed above *(initial all you authorize):*

_____ Lab results

_____ Radiology results

_____ Financial/Billing Information

_____ Disability/FMLA/Medical Insurance

_____ Other: _____

I understand that Rex is not required by law to accept my request, but will make every effort to accommodate reasonable requests for alternative means of communication. If alternative means of billing have been requested, Rex may request information as to how payment will be handled before accommodating the request.

If signing as authorized representative, describe authority to act for patient ***and submit documentation*** showing such authority: _____

_____

_____

This authorization shall be in effect until such time as an updated form is submitted or this form is revoked by the patient or authorized representative.

_____ _____
Signature of Patient/ Authorized Representative Date

_____ _____
Witness Date

REX USE ONLY

Date request received: _____ Accepted or Denied (circle one)

If denied, state reason for denial: _____

_____

Name and Title of Practice/Service Area Manager: _____