

**SOUND INPATIENT PHYSICIANS, INC.
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: _____

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 HOSPITAL'S PRIVACY OFFICER AT THE FOLLOWING ADDRESS:

James Kodjababian, 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: _____