Atchison Hospital Clinics
820 Raven Hill Drive Atchison, KS 66002

Patient's Request for Special Communication

Patient Name: _____ Date of Birth:_____

I request that communication regarding my protected health information that is provided to me, other than verbally and in person be provided to me by sending or calling the information to:

Address:_____

Phone Number(s): _____or_____
YES _____A message can be left at these numbers. (please initial your response)
NO _____A message cannot be left at this number.

AND / OR, I will allow my protected health information to be told to the following individual(s):

Name: _____ Relationship to Patient _____

Address: _____

Phone Number: _____ _____home, _____ cell, _____ work

OR

Name: _____ Relationship to Patient _____

Address: _____

Phone Number: _____ _____home, _____ cell, _____ work

I understand that the above named clinic may choose NOT to agree to such requests.

This request will be kept in place at all times until I revoke this request at any time in writing and submitting such request to the above named clinic.

Signature of Patient: _____ Date: _____

Signature of Personal Representative of Patient: _____

Description of Representative's Authority to Act for patient: _____

Witness: _____ Date: _____