## Clayton Fire Department Request for Alternate Communication Form

Patient Name:		Date	Date:	
Address:				
City:				
Social Security Number:				
Patient Rights: As a patient its business associates send of (e.g., work address) or by an Department will accommodate. Please indicate below your reand/or to a different location.	communications containing alternate method (e.g., te all reasonable requests.	ng your PHI to y e-mail, by telepl	ou to a different location none, etc.). Clayton Fire	
Signature of Patient:				
Please print name:			Date:	
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— OR —

<OVER>

Signature of Authorized Representative:				
Please print name:	Date:			
Please explain Representative's authority to act on behalf of the Patient:				
If Representative's authority to act on behalf of the Patient is based on a written document, please attach a cop of such written document to this Request.				
State of				
On this day of, 20, before me personally appeared, to me known to be the person described in and who signed this Request for Alternate Communication Form, by reviewing his/her driver's license and witnessing his/her execution hereof, and who acknowledged that he/she signed it voluntarily as his/her free act and deed, with full authority to make such request under federal and state law.				
IN TESTIMONY WHEREOF, I have hereunto set my hand County and State aforesaid, the day and year above written.	and affixed my of	fficial seal in the		
My Commission Expires:				
No	tary Public			