Request for Alternative Communications

This form can be used to request that WESTMED Medical Group communicates with you by alternative means or at alternative locations.
In order for our Practice to respond to your request, please complete the entire form.

Patient Name: ____
[print or type].

Proposed Alternative Communication
Please describe in detail your proposed alternative means or location for receiving communications from our Practice.

____
____
____
____

Payment Information
Your alternative communications request may affect our Practice's normal procedure of mailing bills to your home address. Please specify an alternative method for handling payment.

____
____
____
____

Alternative Address or Other Means of Contact
Please specify an alternative address or other means of contact.

____
____
____
____

Contact Person
You may contact our Practice's Privacy Official at 914-681-5291 if you have any questions relating to your alternative communications request.

Patient Information

Signature of Patient or Personal Representative ______________________________

Date ______________________

Name of Patient or Personal Representative ______________________________

Nature of Personal Representative's Authority ______________________________