PATIENT REQUEST FOR ALTERNATE METHOD OF COMMUNICATION

Name of Patient ______________________________________ **Date of Birth** ____________________________

Medical Record # ____________________________ **Phone #** ______________________________________

Patient Address ____

____

Patient Email Address ____

The patient, or his/her personal representative, requests that the University of Utah Health Sciences ("UUHS") communicate to the patient in the following manner or the telephone number/address listed. Please note that this request is applicable only at UUHS and that that patient's insurance will contact you at the address they have on-file.

____

____

____
Signature of Patient or Representative Date

____
If Applicable, Name of Personal Representative*

*Description of Personal Representative Authority

- ☐ Parent
- ☐ Foster Parent
- ☐ Guardian
- ☐ Power of Attorney
- ☐ Other, Explain, attach:

____

Patients: Bring this with you and provide it to the registration clerk, or mail to: Health Information, 50 N. Medical Dr., Salt Lake City, UT 84132

A notarized signature is required unless the patient or personal representative's ID is verified by UUHS staff.

SUBSCRIBED AND SWORN before me this ____ day of ________________, 20____.

____
NOTARY PUBLIC

Residing in ________________________________

My Commission expires: ____________________

Revised 3-10-2016