COMMUNITY HEALTH SERVICES
OF LAMOILLE VALLEY®

Request for a Specified Method of Preferred Communication

Patient Information	
Patient Name:	Request Date:
Street Address:	Birth Date:
City/State/Zip:	Telephone #:
Patient's Personal Representative Name:	

Request for Specified Alternative Confidential Communication Method

I hereby request that communications containing my health information from CHSLV be communicated in the following manner:

❑ At a telephone number other than my home
_____Preferred telephone number is: _____

❑ At a mailing address other than my home mailing address.
Preferred mailing address is: _____

❑ Other: Please specify: _____

❑ Requested Expiration date: _____/____/____

Date: ___/_____/___

Signature of Patient/Representative _____

Print Name of Patient/Representative_____

FOR CHSLV INTERNAL USE ONLY

Date Request Received: ___/_____/____	❑ Accepted	❑ Global Alert Placed ❑ Demographics Updated

_____ ____/_____/____
Signature of CHSLV Representative Date