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Request for Confidential Handling of Health Information

I, _____ request that
(Patient's First and Last Name)

Alvord, Baker & Associates, LLC handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please check and list all means by which you prefer to receive your health information.

Home Telephone: _____

Cellular Phone: _____

Work Telephone: _____

Fax: _____

Email: _____

Postal Service and/or other carrier (UPS, FedEx, et.al.)

Other (please list below)

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence):

5 Hmbhcb. _____

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Street Address

City

State

Zip Code

C. Additionally, I understand that there may be times when I may provide my therapist with additional means for communication, outside of those listed above. It will be understood that these too will be considered patient authorized confidential communications.

Signature

Date

Patient or legally authorized individual signature

Date

Time

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.