3200 Tower Oaks Blvd., Suite 200 Rockville, MD 20852 Phone: 301-593-6554 · Fax: 301-255-0461
11161 New Hampshire Ave., Suite 307 Silver Spring, MD 20904 Phone: 301-593-6554 Fax: 301-754-1034

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 HHYbH]cb. ____

____
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.