GUIDE FOR ALTERNATIVE MEANS OF COMMUNICATIONS

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

DATE OF BIRTH: _____

SPECIFIC CLINIC PATIENT IS SEEN AT: _____

The Health Insurance Portability & Accountability Act (HIPPA) requires the Private Diagnostic Clinic, PLLC ("PDC") to have reasonable safeguards in place to protect our patient's health information. In addition, HIPPA requires the PDC to reasonably limit incidental uses or disclosures of our patient's protected health information (medical records), and agree to reasonable request by our patients to communicate with them by alternative means or at alternative locations.

While we strive to provide our patients with prompt results of clinical and lab tests, the PDC's providers are often asked to disclose the results to spouses, children, significant others, and other medical offices. In addition, some of the PDC's patients prefer to receive messages left on home answering machines or work voice mails. Absent an agreement by a specific PDC clinic or clinical site to the contrary (which shall cover only that particular clinic or clinical site), the PDC reserves the right to use its professional judgment to determine what reasonable actions and safeguards it should take when communicating with its patients and individuals involved in our patients' care. However, to help guide the PDC's judgment, please complete the relevant portions below to help your PDC providers understand what alternative means of communication and disclosures to individuals involved in your care you would prefer so that the PDC providers may use this information to determine reasonable ways to inform you of your test results and other pertinent clinical information:

☐	SPOUSE	Name/Number _____
☐	SIGNIFICANT OTHER	Name/Number _____
☐	CHILD/CHILDREN	Name/Number _____
		Name/Number _____
☐	WORK VOICE MAIL	Number _____
☐	ANSWERING MACHINE	Number _____
☐	DR. OFFICE	Name/Number _____
		_____
☐	OTHER	_____

This form shall be used as a guide by the PDC providers. and it is not to be an agreement by the PDC to accept any restrictions or protections of the patient's protected health information requested by the patient or the patient's personal representative. In addition, this form is not a conclusive determination by the PDC that your requests for communications by alternative means or at alternative locations are reasonable. Further, this form shall be used only by the particular clinic or clinical site listed herein.

Signature: _____ Date: _____