



**GARNER RHEUMATOLOGY
& INFUSION CENTER**

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ALTERNATIVE/CONFIDENTIAL COMMUNICATIONS REQUEST FORM

I, _____, request that Garner Rheumatology and Infusion Center, PLLC (“*Practice*”) use alternative, confidential communication of my health information when my health information is disclosed on my behalf. Please use the following address or manner in disclosing my health information to me:

_____ My initials here affirm that failure to disclose my health information in the non-conforming manner stated above could endanger me.

Patient Signature: _____ Date: _____ DOB: _____

Patient Printed Name: _____

Privacy Officer Action / Comments:	
<input type="checkbox"/> Agrees to Entire Request.	
<input type="checkbox"/> Denies Requested Action In Part: _____	
<input type="checkbox"/> Requires More Complete / Specific Information to Assess Request.	
<input type="checkbox"/> Practice Cannot Reasonably Accommodate the Request.	
<input type="checkbox"/> Patient Contacted	
Signature of Privacy Officer: _____	Date: _____