UNC HEALTH CARE SYSTEM
REQUEST FOR ALTERNATIVE MEANS OR LOCATION FOR CONFIDENTIAL COMMUNICATIONS

Patient Name_____ Medical Record Number_____
Date of Birth_____ Phone #_____
Patient Address_____
_____
Social Security Number (voluntary)_____

I request an alternative means or location of confidential communications to me from UNC HCS in the following alternative location or manner (please be as specific as possible).

_____

_____

_____

_____

I understand that UNC HCS is not required by law to accept my request, but will make every effort to accommodate reasonable requests for alternative means of communication. If alternative means of billing have been requested, UNC HCS may request information as to how payment will be handled before accommodating the request.

I understand that if this request is accepted and put into place, it may make UNC HCS ability to communicate with me more difficult and/or less effective.

_____ _____
Signature of Patient or Authorized Representative Date

If signing as authorized representative, describe authority to act for patient and submit documentation showing such authority:_____
_____

UNC HCS USE ONLY

Date request received:_____ Accepted or Denied (circle one)

If denied, state reason for denial_____

Method used to communicate decision to the patient: _____

Name of staff member: _____ Date_____