MARSHALL MEDICAL CENTER
ALTERNATE CONFIDENTIAL COMMUNICATION REQUEST

Name: _____ **Date of Birth:** _____

I am requesting the use of the following alternate confidential methods for the communication of information related to my personal health, treatment, or payment for services. I understand this request supersedes any prior request for alternate confidential communication methods I may have made. I understand this request does not expire until I submit a written revocation.

Please select all that apply:

☐ PHONE

I want you to contact me by telephone at: _____

☐ **Do** ☐ **Do not** leave messages on my answering machine.
☐ **Do** ☐ **Do not** leave messages with any other person.

☐ MAIL

Address: _____

☐ FAX

Fax Number: _____

☐ E-MAIL

E-mail address: _____

I understand that Marshall Medical Center will transmit a proxy message with a link to its secure encrypted email repository. The site will require that I login with my credentials or a one-time password to retrieve the message.

_____ _____
Signature of patient or patient's personal representative Date

_____
Print Name

For MMC Use Only:

Date received:	Processed by: