

PIEDMONT MEDICAL ASSOCIATES, P.A  
3400 Executive Drive, Suite 205  
Raleigh, NC 27609

PATIENT REQUEST FOR ALTERNATIVE METHOD OF  
COMMUNICATION

Patient Name: \_\_\_\_\_

Proposed Alternative Communication: (Please describe how or who you would like us to contact as an alternative, or how else your information should be released.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Payment: If your request for alternative communication affects our regular procedure for mailing bills to your home, please provide an alternative billing statement mailing address:

\_\_\_\_\_  
\_\_\_\_\_

PATIENT INFORMATION:

Patient Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Patient's Date of Birth or Other Identification Number: \_\_\_\_\_

Today's Date or Effective Date: \_\_\_\_\_

PATIENT'S PERSONAL REPRESENTATIVE (If applicable):

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I hereby certify that I have legal authority under applicable law to make this request on behalf of the patient mentioned above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_