UT Southwestern Medical Center

Alternate Communications Request Form

Pt. Name:_____

Address:_____

_____
City State Zip

MRN: _____

DOB: _____

SEX:_____

DOS: _____

Request for Alternate Communications Regarding Medical Information

Date:_____
Month / Date / Year

I wish to request that UT Southwestern Medical Center communicate with me about all medical and billing matters in the following manner:

I am aware this request will apply to all UT Southwestern Medical Center Ambulatory Services until modified: (Fill in the circle to all that apply)

◯ Leave the above listed messages at the following alternate telephone number ( )_____

◯ All medical and billing correspondence from Southwestern Medical Center should be sent to the following alternate address:

Street:_____ P.O. Box:_____

City:_____ State:_____ Zip:_____

◯ For other requests, please contact the UT Southwestern Privacy Officer at 214-648-6080.

We will accommodate all reasonable requests. The determination of reasonableness may be based solely on the administrative difficulty of complying with the request.

If you cannot be reached at the designated alternate location or contact number you specify, Southwestern Medical Center or our designated billing agent may use any other means to contact you for payment.

Signature of Patient/Responsible Party (Relationship to Patient)		Time	Date
Printed Name of Patient		Time	Date
Signature of Witness	Address / City / State / Zip Code	Time	Date
Printed Name of Witness			

FOR OFFICE USE ONLY:

Above Information Changed

◯ EPIC_____ Date_____ By_____
Staff Signature

Form # AMA/ACRF-001 / 02.04 (Rev. 03.26.13) (Reviewed 09/13) Original - Health Information Management Department Copy - Privacy Officer