Request to Have Medical Information Relayed by Alternative Means

As a patient at Central Carolina Surgery, you have the right to ask that medical information, including billing information, be communicated to you by alternative means. We will accommodate all reasonable requests.

Patient Name: ____

Birth Date: ____

I request that Central Carolina Surgery to contact me in the following manner (indicate all that apply):

___ By telephone: ____

___ By mail: ____

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___ By email: ____

___ By fax: ____

__By other means (please specify: Telehealth______________________________

I understand that if Central Carolina Surgery cannot accommodate this request, I will receive notification in writing. Otherwise, this request will remain in effect unless changed by me while I am a patient at Central Carolina Surgery. It is my responsibility to notify Central Carolina Surgery of changes and to complete a new form.

Patient Name: ____ Phone: ____________________

Patient Signature: ____________________________________ Date: ____________________

Witnessed By: ____ Date: ____________________