Request for Alternative Communications

This form can be used to request that WESTMED Medical Group communicates with you by alternative means or at alternative locations.

In order for our Practice to respond to your request, please complete the entire form.

Patient Name: ____ **Patient Date of Birth**: ____________________

Print Name *Month/Day/Year*

Proposed Alternative Communication

Please describe in detail your proposed alternative means or location for receiving communications from our Practice.

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Payment Information

Your alternative communications request may affect our Practice's normal procedure of mailing bills to your home address. Please specify an alternative method for handling payment.

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Alternative Address or Other Means of Contact

Please specify an alternative address or other means of contact

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Name of Patient or Personal Representative: ____

Print Name

Signature of Patient or Personal Representative: ____

Description of Personal Representative's Authority: ____

Date: ____

Please return form by using one of the methods listed:

- Mail to: Compliance Officer, WESTMED Practice Partners, 2700 Westchester Avenue, Purchase, NY 10577
- Fax: 914-719-4707
- *Email: Compliance@westmedgroup.com

**Disclaimer: Patients should carefully consider the use of email for the communication of protected health information (PHI) and should understand that there are known and unknown risks that PHI may be disclosed to, or intercepted by, unauthorized third parties. These risks include but are not limited to (i) the email being sent to the wrong person due to the sender's use of the wrong email address, (ii) e-mail service provider's ability to archive and inspect communications, and (iii) computer hacking and viruses.*