FIRE PROTECTION DISTRICT NUMBER FOUR ST. TAMMANY PARISH LOUISIANA, HEALTH CARE COMPONENT - CHAPTER 16, Request for Communications by Alternative Means

PATIENT REQUEST FOR COMMUNICATION BY ALTERNATIVE MEANS

Patient Complete Legal Name: _____

Current Address: _____

Date of Birth: _____ Social Security No. _____ Tel. _____

NOTICE TO PATIENT: Your request for communication by alternative means is applicable only to District Four's Health Care Componenet. If you would like communication maintained by other health care providers to be by other means, you must submit a separate request to each health care provider.

Requested Alternative Means of Communication:

☐ Alternative Phone Number: _____

☐ Alternative Mailing Address: _____

☐ Other Alternative Means of Communications: _____

My request applies to:

☐ Communications about this date of treatment only (indicate date) _____ or

☐ Communications from this date of treatment (indicate date) _____ until I indicate otherwise, or

☐ From _____ to _____

Signature: _____ Date: _____
(Patient or Personal Representative)

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE:

Type of authority (e.g., court appointed, custodial parent): _____

For District Four Health Care Component Use

Approved: ☐ Denied: ☐

Signature of District Personnel: _____ Date: _____

Print Name: _____

Reason for Denial: ☐ Too expensive ☐ Administratively impractical ☐ Patient failed to provide information as to how payment, if applicable, will be handled ☐ Patient failed to specify an alternative address or method ☐ Additional explanation _____

FILE IN PATIENT RECORD