Ohio Infrared Health

CONTACT INFORMATION

Patient Name: _____

As allowed by Privacy Regulations, I wish for Ohio Infrared Health to provide the following "alternative" means of communicating my Protected Health Information:

Mailing address: _____

Contact phone numbers:

Home: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Work: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO
Cell: _____	Confirm Appointments OK?	YES	NO
	Detailed Message OK?	YES	NO

Would you like to receive E-mails regarding special offers or promotions? YES NO

E-mail: _____

Other person authorized to receive message/information: _____

Relationship to patient: _____

How would you like to be reminded when it's time for your annual or follow-up appointments?

E-mail	YES	NO
Phone	YES	NO
Mail	YES	NO

I have the following additional requests for confidential communications regarding my Protected Health Information:

_____

_____ _____

Signature Date

How did you hear about Ohio Infrared Health? _____