Kathy E Wolf MD PC
Bringing hope through compassionate healthcare

HIPAA Request Form for Alternative Communications

Patient name______________________________________ Date of Birth__________

I authorize the practice of **Kathy E. Wolf, M.D., P.C.** to contact me and leave a message by any of the following alternative means of communication regarding my protected health information, including lab results, sonograms, etc. (**please number inside the box provided the order in which you would like to be contacted**):

☐ Home ____________________________________

☐ Work _____________________________________

☐ Cell ______________________________________

☐ Email ____________________________________

☐ Please check here if you would NOT like to be contacted via email.

☐ Other (please specify) ________________________

I hereby authorize the practice of Dr. Kathy Wolf to discuss my protected health information to the following person(s):

Name	Relationship	Contact Phone Number

This form of communication will be used as the standard form of communication until I revoke this in writing.

Patient/Guardian Signature____

Date signed ______________

Updated 02/2017