Facility Name or Logo: On-Site Solutions Physical Therapy	*Protected Health Information Alternative Communications Request Form*	Revision Number: 1-2024

Patient to complete the following information:

Patient Name: _____

Date: _____

Request

I wish to receive communication of my Protected Health Information from On-Site Solutions Physical Therapy by the following means:

_____

_____

_____

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

Protected Health Information Alternative Communications Request Form

Facility to complete the following

Date the request was received: _____

Alternative communication has been:

- ☐Accepted
- ☐Declined: The request is not reasonable because:

_____

_____

_____

Completed by	
Signature of Facility Representative	
Date	