|  |
| --- |
| **Route To:** |
| **[X]** | **Billing** |
| **[ ]**  |  |
| **[ ]**  |  |

|  |  |
| --- | --- |
| ou-logo | **The University of Oklahoma** |

**Request for Alternative Means of Communication—Health Sciences Center**

|  |
| --- |
|  |
| Last Name: |  | First: |  | Middle: |  |
| Other Names Used: |  | Date of Birth: |  |
| Address: |       | City: |       | State: |       | Zip: |       |
| Home Phone: | ( )       |  Alt. Phone: | ( )       |  Cell Phone: | ( )       |
|  |

**NOTICE TO PATIENT:** Your request for communication by alternative means is applicable only to the information maintained by the University of Oklahoma entity named above. If you would like an alternative means of communications from any other University entity, a separate request must be submitted to that University entity. (This request is applicable only to communications made by the OU Health Sciences Center.)

My request for alternative means of communication applies to the following providers associated with the University of Oklahoma Health Sciences Center:

|  |  |
| --- | --- |
| **Name of Physician or Other Provider** | **Department / Clinic** |
|            |       |
|       |       |
|       |       |
|       |       |
|       |       |

|  |
| --- |
| **REQUESTED ALTERNATIVE MEANS OF COMMUNICATION (check applicable box and fill in the blank):** |
| **[ ]**  | Alternative Phone Number: | (       )       |
| **[ ]**  | Alternative Mailing Address: |  |
| **[ ]**  | Other Alternative Means of Communication: |  |
| **How and by whom will payment for services be made?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**If you believe that disclosure of part or all of your information could put you in danger, please provide a statement to that effect:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**My request applies to:** |
| **[ ]**  | Communication about this date of service only (indicate date):\*\* |  | , or |
|  |  |  |  |
| **[ ]**  | Communications from this date of service (indicate date): |  | until I indicate otherwise, or  |
|  |  |  |  |  |
| **[ ]**  | Communication From this date: |  |  to this date: |  |
|  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title, if Legal Representative\* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date |
|  |  | \*May be requested to submit evidence of representative status |

 **FOR CLINIC USE ONLY:** [ ]  **Request APPROVED** **[ ]  Request DENIED**

**By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
|  Signature | Title |  |  Date |
| **Reason for Denial:** | [ ]  | Too expensive to accommodate request. |
|  | [ ]  | Administratively impractical to accommodate request. |
|  | [ ]  | Patient failed to provide information as to how payment, if applicable, will be handled. |
|  | [ ]  | Patient did not specify an alternative address or method of communication. |
|  | [ ]  | Other |       |
| Additional Explanation: |       |

**Notice of Denied requests should be given to the patient during the visit to the office or sent via the alternative means above.**

**\*\* In most cases, changing means of communication, if approved, may take up to 14 University business days.**

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129