

Innovative Thermal Imaging/The Breast Thermography Center

CONTACT INFORMATION

Patient Name: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following “Alternative” means of communicating my Protected Health Information:

Mailing Address

If different than listed address:

Contact Phone Numbers

Which number would you like us to use?

- Home: _____
- Work: _____
- Cell: _____

E-Mail

If appropriate, please contact me by E-mail at the following address:

- I would like to receive E-mails regarding special events, special offers and health information.

Fax

If appropriate, please contact me by fax at the following number:

How would you like to be reminded of when it’s time for your follow-up appointments?

- E-mail
- Phone (see above)
- Mail
- Fax

I have the following additional requests for confidential communications regarding my Protected Health Information: (please explain)

Our Policy is to call and review your report over the phone. If you would like to receive this call which number would you like us to use? (see above)

Signature

Date