Health
AUGUSTA UNIVERSITY

DOB: EMRN:
ACCT #:
LOCATION:
* - - *

Request for Confidential Communications

Patient Name:	Patient Number:
Date of Birth:	Last 4 Digits of Social Security Number:

I would like to request an alternative address and/or method of contact for communicating my health care information. Please mail all future communications to:

Street Address: ______________________________

City, State, Zip ______________________________

Contact me at the following alternate telephone number (if applicable):

____

I would like to opt-out of the automated phone appointment reminders.

____
Signature

Fees: No fee will be charged for accommodating this request. However, AU Health reserves the right to deny requests determined to be of an unreasonable nature, or assess fees for requests that require on-going attention or excessive maintenance.

Conditions: I understand that by requesting an alternate mailing address and/or telephone contact number for communications from AU Health. I am requesting that all communications be sent to the alternate address and all telephone contact be made by the alternate telephone number until further notice is provided by me in writing.

______________________________ ____________ ____________
Signature of Patient or Legal Representative Date Time

Mail to: AU Medical Center
Privacy Officer
Compliance and Enterprise Risk Management
1120 15th Street
Augusta, Georgia 30912

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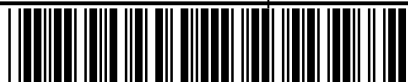
** FOR AU HEALTH USE ONLY **

Date Request Received:	Request Granted: ☐ No ☐ Yes
Date Patient Notified:	If No, Reason for Denial:
Staff Member Processing Request:	



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