Salem Health®
Hospitals & Clinics

Request for Confidential Communication

PATIENT CONTACT INFORMATION			
Patient Name:		Date of Birth:	
Phone #:		Medical Record # (optional):	
Street:	City:	State/Zip:	

REQUEST

I request to be communicated with using an alternative means. When Salem Health contacts me or my personal representative to provide any information about my health care condition, treatment, or payment, Salem Health should use the confidential communications described below:

PLEASE DESCRIBE THE ALTERNATIVE COMMUNICATION CHANNEL OR METHOD TO BE USED

Signature
(If signed by a personal representative, please print the following) ***Date***

Personal representative name:

Relationship to Patient:

This request does not guarantee that all Salem Health providers who previously collected contact information from you will receive this request. You are responsible to address your communication concerns at the time and location where you received services.

Please return completed form to:

Salem Health Privacy Officer
Corporate Integrity Office
P.O. Box 14001
Salem, OR 97309-5014