FORM: HIPAA REQUEST FOR ALTERNATIVE COMMUNICATIONS

Use this form to make a request to Vital Tears that we communicate with you by alternative means or alternative locations.

In order for Vital Tears to respond promptly and accurately to your Alternative Communications Request, please complete this form in its entirety.

Last Name			First Name		Middle Name		
Birth Date	**Month**	**Day**	**Year**	**Today's Date**	**Month**	**Day**	**Year**
Address			**City**	**State**	**Zip**	**Phone**	

PROPOSED ALTERNATIVE COMMUNICATION **Please describe in detail your proposed means or location for receiving communication from Vital Tears. For instance, if you wish for us to communicate with you only at a specific address or specific phone number.**	
ALTERNATIVE ADDRESS OR OTHER MEANS OF CONTACT **Please specify an alternative address or other means of contact for how you would like us to contact you.**	

Signature of Patient	**Date**

FOR PERSONAL REPRESENTATIVES OF THE PATIENT	
Name of Personal Representative	**Relationship to Patient**
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the individual/patient identified above.	
Signature of Personal Representative	**Date**

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Please return this form to this address. Or, call this number with questions:	Michelle Haider Vital Tears HIPAA Privacy Officer mhaider@saving-sight.org 10560 N. Ambassador Dr. Suite 210 Kansas City, MO 64153 (816) 255-1387