



## REQUEST FOR FORMS OF COMMUNICATION

### ARIZONA

3861 N. First Avenue • Tucson, AZ 85719

P (520) 209.1755 • F 520.798-2468

[Lynda@ProactiveHealthSolutions.org](mailto:Lynda@ProactiveHealthSolutions.org) <OR>

[BBridges@ProactiveHealthSolutions.org](mailto:BBridges@ProactiveHealthSolutions.org)

### CALIFORNIA

1901 Newport Blvd. #350 • Costa Mesa, Ca 92627

P (714) 891.3390 • F (714) 893.5326

[Brenda@ProactiveHealthSolutions.org](mailto:Brenda@ProactiveHealthSolutions.org)

### Client Info

NAME

DATE OF BIRTH

PHONE NUMBER

EMAIL ADDRESS

In general, the HIPAA privacy rule gives individuals the right to request confidential communications, or that a communication of private health information be made by alternative means. Proactive Health Solutions will **email** your report and images in PDF format (password secure) to the address you provide. You can expect that email from one of the Arizona or California PHS representatives listed above when communicating about your report.

### I May Be Contacted in the Following Manner (Please INITIAL ALL THAT APPLY):

HOME PHONE\*

OK TO MAIL TO MY HOME ADDRESS

WORK PHONE\*

OK TO MAIL TO MY WORK/OFFICE

CELL PHONE\*

**OK TO EMAIL TO ADDRESS PROVIDED ABOVE\*\*.**

\*No detailed messages regarding your thermal reports will be left on any voice mail systems.

\*\* **Please note:** Your written medical reports from the reading Thermologist, along with your color images, will be created as a PDF document. This format allows for your reports to be **secured with a password**. You will also be able to save these documents on your computer and forward to your medical professional(s) as you see fit.

### I Understand & Agree to the Following (Please INITIAL ALL):

I certify that the email address provided on this request is accurate and that I accept responsibility for email communications sent to or from this address.

I have received a copy of the IMPORTANT INFORMATION ABOUT CLIENT EMAIL.

I understand that I will be responsible for forwarding all thermal reports and images to my preferred healthcare providers for their use of electronic medical records (EMR).

I agree to hold harmless Proactive Health Solutions, LLC and individuals associated with it from any and all claims and liabilities arising from or related to this request to communicate using alternative or varying methods.

*Signature of Patient or Patient's Authorized Representative*

*Date*