Hospice of Central New York & of the Finger Lakes

Return completed request to:
Hospice of Central New York and Hospice of the Finger Lakes
990 Seventh North St.
Liverpool, NY 13088
Phone (315) 634-1100
Fax: (315) 766-1125

Patient Request for Alternative Communications

Patient's Name: _____

Address: _____

Phone#: _____ MR#: _____

I am requesting that Hospice communicate with me in the alternative manner and/or location described below regarding my health information. I understand that Hospice may deny this request if it imposes an unreasonable administrative burden.

Description of the health information to be communicated by this request:

_____

_____

Alternative Communication Requested: I request that Hospice communicate with me in the following manner and/or location: *(check one or both)*

❒ Alternative Method: _____

❒ Alternative Location: _____

If I request communication by email:

E-mail address: _____

1. I understand that email communication has a number of ***RISKS*** that should be considered. These include, but are not limited to, the following:
   - E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   - E-mail senders can easily misaddress an E-mail.
   - Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
   - Employers and on-line services have a right to inspect E-mail transmitted through their systems.
   - E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
   - E-mail can be used to introduce viruses into computer systems
   - E-mail is not encrypted and may be accessed by others.
   - There may be a **DELAY** in email communications whereby they may not be received and read the same day.
2. If I need to contact Hospice urgently, I agree to call Hospice by phone: **(315) 634-1100**

By signing this form, I am confirming that it accurately reflects my wishes.

_____ _____

Patient/Personal Representative Signature *Date*

If signed by Personal Representative*: Print Name*: _____

Relationship to patient/nature of authority: _____ Phone: _____