ADVANCED THERMOGRAPHY OF SOUTH FLORIDA
DIGITAL INFRARED THERMAL IMAGING

Request for Alternative Communications

DATE OF REQUEST: _____ /_____ /_____

DOB: _____ /_____ /_____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

EMAIL_____
Please contact me by email at the above email address

I have made the following request for confidential communications regarding my Protected Health Information:

I authorize **Advanced Thermography of South Florida** to email my Thermography report and images.

X_____ **Date**_____
Signature of Patient or Patient's Authorized Representative