REQUEST TO USE ALTERNATIVE CONTACT INFORMATION

You have the right to request that Erie County use alternative methods of communication, or alternative locations to receive communications. Please refer to the Erie County Notice of Privacy Practices for a more detailed description of your rights. If you would like to request that we use an alternative method or location for communications, please complete and return this form to:

Erie County Chief Privacy Officer 95 Franklin Street, Room 1634 Buffalo, NY 14202 Chief.Privacy.Officer@erie.gov

CONTACT	INFORMATION
PATIENT NAME:(please print)	
PHONE NO.:	
DATE OF BIRTH:	
MAILING ADDRESS:	
EMAIL:	DATE OF REQUEST:
DESCRIPTION	ON OF REQUEST
 Please indicate which of the following department(s information provided herein: Department of Emergency Services Department of Health Department of Mental Health Other Please describe your requested accommodation(s): 	of Erie County you would like to use the alternative contact Department of Senior Services Department of Social Services Youth Services below:
Please write the address where we can send information.	ation (if different from above):

4. PREFERRED PHONE NUMBER

	(circle "\	(circle "Y" if okay)	
Please list phone number(s) and indicate wheth we may call you at the number and/or leave a n	ner Okay to call?	Okay to leave message?	
Home:	_ Y	Υ	
Work:	_ Y	Υ	
Cellular:	_ Y	Υ	
Other:	_ Y	Υ	
5. PREFERRED BILLING ARRANGEMENT			
Please specify your preferred billing arrangeme	nt (if applicable) below:		
I have read, understand and had an opportun			
certain circumstances, Erie County may den reasonable cost-based fee for expenses such a			
SIGNATURE:	DATE: _		
NAME AND ADDRESS OF PERSONAL REPR	RESENTATIVE (if applicable):		
PERSONAL REPRESENTATIVE'S AUTHORIT	ΓΥ (supporting documentation is	required):	
Parent Health Care Agent Other:	Court-Appointed Power of Attorne Administrator/Fx	ey	

VERIFICATION REQUIREMENTS		
For in-person requests for an amendment of health information, patients and authorized representatives can meet verification requirements with one of the following:		
 ☐ In-person patient request verified by government-issued photo identification (copy of ID to be retained with request) ☐ In-person request by authorized third party - parent, legal guardian, or other court-appointed representative verified by government issued photo ID <u>and</u> copy of appointing document (copy to be retained with request) 		
Notarization is required for requests submitted to Erie County by mail. An authorized representative must also submit a copy of the appointing document. The notary public or other officer authorized to take and certify acknowledgments and administer oaths must complete the following:		
STATE OF NEW YORK		
COUNTY OF		
On the day of in the year before me, the individual referenced above, personally appeared and proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this form and acknowledged to me that he or she executed the same in his or her capacity, and that by his or her signature(s) on the form, the individual executed the form.		
Notary Public		
Printed Name: My Commission Expires:		
FOR ADMINISTRATIVE USE ONLY: Date Received: Request has been: Accepted Denied Staff member: Title:		

This information should be placed in a prominent location in the record to remind staff to use alternative addresses and/or phone numbers.