

# Jewish Hospital & St. Mary's HealthCare

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|--|---|---|--|
| <input type="checkbox"/> Jewish Hospital         | <input type="checkbox"/> JH Shelbyville         | <input type="checkbox"/> Frazier Rehab Institute  | <input type="checkbox"/> Our Lady of Peace   |
| <input type="checkbox"/> JH Medical Center East  | <input type="checkbox"/> VNA Nazareth Home Care | <input type="checkbox"/> Frazier Rehab Outpatient | <input type="checkbox"/> Employed Physicians |
| <input type="checkbox"/> JH Medical Center South | <input type="checkbox"/> Sts. Mary & Elizabeth  | <input type="checkbox"/> JH Meade Co.             |  |

## JEWISH HOSPITAL & ST. MARY'S HEALTHCARE, INC. REQUEST FOR CONFIDENTIAL COMMUNICATION

You have the right to request to receive confidential communications from Jewish Hospital & St. Mary's HealthCare, Inc. (JHSMH), by alternative means or at an alternative location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We also may condition this accommodation by asking you how payment will be handled or specification of an alternative address or other method of contact.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City, State, ZIP Code:** \_\_\_\_\_

I hereby request Jewish Hospital & St. Mary's HealthCare communicate with me:

*(Check one and complete necessary information)*

By mail at \_\_\_\_\_  
Street Address City State ZIP

By telephone at \_\_\_\_\_  
Area Code Telephone Number

Other: \_\_\_\_\_

**Specify address or other method of contact for payment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If patient is unable to sign, secure authorization of Legal Representative and indicate reason below:

Minor  Incompetent  Other

**Signature of Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**JHSMH Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Title:** \_\_\_\_\_

Please take completed form with you when your Register at a JHSMH facility.

Consent Forms

