Hill Physicians

Alternative Communication Request

To request an alternative form of communication from Hill Physicians, please complete and mail the request form.

Is this request for yourself? (Required)

☐ Yes, this request is for myself ☐ No, this request is on behalf of someone

Individual's First and Last Name

Prefix ________ First ________________________________ Last ______________________________________

I am the authorized representative of: (Required) ____

I am submitting this request for an alternative method of communication for and on behalf of the above Individual for the following reason:

____

____

____

Individual's Health Plan Member Number: (Required)

____

I request that Hill Physicians Medical Group, and any of its business associates, who has or will have a need to communicate with the above name Individual for any reason, to do so in the following manner or to the following location: (Required)

☐ Contact me by mail (Please specify) ☐ Contact me by phone (Please specify)

☐ Contact me by email (Please specify)

If by mail, please forward any information to the following address: (Required)

*Please specify address here ____

If contact is made by telephone, please contact me or my representative at: (Required):

*Please specify phone number here ____

If contact is made by e-mail, please contact me at: (Required)

*Please specify e-mail address here ____

—Form continued on back

Hill Physicians

Consent (Required)

☐ **The request for an alternative method of communication between Hill Physicians Medical Group and myself is made on the belief that disclosure of this information in the normal course of business may endanger my welfare.**

Consent (Required)

☐ **I understand that Hill Physicians may not accept my request for an alternative method of communication if the request is unreasonable, as determined by Hill Physicians, or could not be reasonably accommodated in the normal course of business.**

Signature ______________________ Print Name ______________________

Your Title ______________________ Dated ______________

Please return this form to Hill Physicians by mail or fax:

Mail

Hill Physicians Medical Group
Attn: Customer Service
P.O. Box 5080
San Ramon, CA 94583

Fax

(925) 327-6626
Attn: Customer Service

© 2024 Hill Physicians Medical Group, Inc. | HP-CSM24-017-01 (04/24)