

**ARTHRITIS AND RHEUMATISM ASSOCIATES, P.C.**

**REQUEST FOR SPECIAL METHOD OF COMMUNICATION**

**PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
Apartment #

\_\_\_\_\_  
City, State Zip

Method of Contact:  
\_\_\_\_\_

Location of Contact: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date