# Request for Confidential Handling of Health Information

Client Name _____ DOB_____

I _____ request that Ann Arbor Consultation Services handle my (or my child's; child's name is _____) confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please describe the alternative means (e.g., US mail, telephone call, etc) by which you prefer to receive your health information:

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence)

_____
Street Address

_____ _____ _____
City State Zip

_____ _____
Client/Guardian Signature Date

_____ _____
Witness Signature Date

Ann Arbor Consultation Services
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