State of Illinois
Department of Human Services

Office of Mental Health and Developmental Disabilities

Request Communications By Alternative Means Or Location

Instructions: RETURN THIS FORM TO THE PRIVACY OFFICER AT THE OFFICE OF MENTAL HEALTH/OFFICE OF DEVELOPMENTAL DISABILITIES-DEPARTMENT OF HUMAN SERVICES FACILITY.

Effective Date: ______________________________

Patient Name: ______________________________ Date of Birth: ____________________
(Last, First Name)

Accommodations Required:

Address Where We Can Send Information:

Phone Number: ____________________

Check if approved

☐ Approval to call? Yes ☐ Approval - message? Yes

Other Address Or Contact Information

Phone Number: ____________________

Name: ______________________________

Home: ______________________________

Work: ______________________________

Check if approved

Cellular: ______________________________ ☐ Approval to call? Yes ☐ Approval - message? Yes

Relationship to individual: ____________________

Phone Number: ____________________

Name: ______________________________

Home: ______________________________

Work: ______________________________

Check if approved

Cellular: ______________________________ ☐ Approval to call? Yes ☐ Approval - message? Yes

Relationship to individual: ____________________

Billing **Arrangements (if apply)**

Signature of Individual: ______________________________ Date: ____________________

Signature of Parent/Guardian to Individual: ______________________________ Relationship: ____________________

Signature of Privacy Officer/Designee: ______________________________ Date: ____________________