AUTHORIZATION ON THE METHODS OF CONFIDENTIAL COMMUNICATIONS

Date: ____________________________________

Name of Patient: ____________________________________

Date of Birth: _______________________________________

You may request on this form how you prefer to receive confidential communications of your protected health information ("PHI") from your therapist. Please specify how and where you authorize to be contacted by your therapist:

1. By Mail at ____
2. By Telephone at ____
3. By E-mail at ____
4. Other: ____

Signature of patient/representative:_______________________ Date:________

If representative give nature of relationship: __________________________

Signature of Provider:___________________________________ Date:________

*For more information about your privacy rights, see the "Notice of Privacy Practices" that was given to you by your therapist.

For Provider Use Only

Request(s) Accepted: ☐ Mail ☐ Telephone ☐ E-mail ☐ Other

Requests) Denied: ☐ Mail ☐ Telephone ☐ E-mail ☐ Other

Provider Signature:___________________________________ Date:__________

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