



Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_

In General, the HIPAA Privacy Rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of 'PHI' (Protected Health Information) be made by alternative means such as sending information to the individuals office instead of their home.

I wish to be contacted in the following manner (check all that apply)

**Home Telephone:**

Okay to leave message with details

Leave Message with only call back phone number

Okay to speak to spouse                      Other \_\_\_\_\_

**Written Communication:**

Okay to Mail to my home

Okay to mail to my work

Okay to fax to designated phone #

**Work Telephone:**

Okay to leave message with details

Leave message with only call back phone #

I give Covenant Counseling & Family Resource Center permission to use and disclose PHI necessary to carry out Treatment Payment or Operations. This also indicates a good faith effort was made on behalf of the Covenant Counseling & Family Resource Center.

By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for 5 years.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date