**Patient Confidential Communications**

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request thatLas Vegas Family Therapy Center communicates financial and/or medical information to you in confidence by a particular method or certain locations.

In order to protect the privacy and confidentiality of your information; please complete the following which tells me how you would like to be contacted.

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

**Phone Communications**

\_\_\_\_ Home Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Work Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Cell Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Do not contact me at home

\_\_\_\_ Do not contact me at work

\_\_\_\_ Leave message with your name and call-back # on answering machine

\_\_\_\_ Leave message with medical information on answering machine

\_\_\_\_ OK to give information to following family member(s), friend/s or co-workers, or others listed below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Written Communication**

\_\_\_ Do not send written medical information to me

\_\_\_ Mail information to my home address on file

\_\_\_ Mail to my work/office address on file

\_\_\_ Mail information to other address:

List \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Fax to the following number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ I do not want to communicate by E-mail

\_\_\_ You can communicate via E-mail with me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Las Vegas Family Therapy Center will continue to communicate with you according to your above response(s) until you change your preferences. You may do so by completing a new form.

By your signature below, you agree to be communicated in the above manner.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_