

Juliet West Counseling

Client Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that **Juliet West Counseling** 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 _____

Juliet West Counseling 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.

Client Signature _____

Client Name _____ Date _____