NewPoint of View Counseling

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Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that **Claudette Waite** 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 _____

Claudette Waite 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 _____