Audrey Lewis, LCSW

Patient Confidential Communications

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that [provider's name] 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

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 _____

Audrey Lewis, LCSW 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 _____