

Alternatives in Psychological Consultation Request for Confidential Handling of Health Information

We may receive requests to release your person health information. Your information WILL NOT be released without your permission or unless ordered by law. However, if such a request should arise, you have the right to indicate the method in which you would like your health information shared.

Client Name _____ ID No. _____

I, _____ request that
(Print First and Last Name of client)

Alternatives in Psychological Consultation, S.C. handle my confidential
(name of practice)
health information in the following way(s):

A. All reasonable requests to receive communication of your health information by alternative means will be granted. **Please initial** the means by which you prefer to receive your health information.

_____ Mail

_____ Fax

_____ Telephone

_____ Other: _____

_____ No Preference

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. **Please complete the following section only if you want communications regarding your health care information sent to an alternate address other than your residence.**

(Street Address)

(City) (State) (Zip Code)

X _____
(Client Signature) (Date)