



### Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this *Communication Consent Form*.

Preferred EAP will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, answering machine, work telephone, voice mail, cell phone and or/pager. When we place telephone calls and an answering machine responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.

I, \_\_\_\_\_ authorize Preferred EAP to contact me and or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify Preferred EAP whenever this information changes:

- Home Mailing      \_\_\_Yes      \_\_\_No
- Home Telephone    \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Answering Machine \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Work Telephone    \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Voice Mail        \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Cell Phone        \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Pager              \_\_\_Yes    # \_\_\_\_\_    \_\_\_No
- Fax PHI            \_\_\_Yes    # \_\_\_\_\_    \_\_\_No

Who may be contact in case of an emergency?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Please list names of other people authorized to receive information about your care:

Spouse: \_\_\_\_\_

Parent: \_\_\_\_\_

Friend: \_\_\_\_\_

Other: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Needed if child is less than 14 years of age)

Witness Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_