AR PSYCHIATRIC AND COUNSELING CENTER

Consent for Communication

Patient Name:_____ Date:_____

Most patients have family members and friends that occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; or your adult child calls with questions about your medication; or a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

If you have anyone that you would allow us to communicate with, please list them below. Due to privacy regulations, we cannot speak to anyone but the patient unless we have your written permission.

I give the ARPCC Clinic staff my permission to speak with the following individuals regarding my care.
Note: If you prefer that we not speak with ANYONE, please write "No One" across the lines

Name of Family or Friend	**Relationship**

Restrictions to Communications: _____

_____

I request that all communications (by telephone, mail or otherwise) by ARPCC Clinic staff be handled in the following manner:

* For written communications Address to: _____

_____

_____

* For oral communications Call: _____
(Telephone number)

May we leave a message? ☐ Yes ☐ No

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the following manner and authorize AR Psychiatric & Counseling Center staff to disclose information only to those individuals listed above **and** in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____
Signature of Patient/Legal Guardian (minors 12-17 must sign) Date

_____ _____
ARPCC Staff Date