Chart #: _____

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, (Client Name): _____ 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:

Please fill in your email below – if you do not have an email please enter NONE and check off NO for the Survey, Newsletter and Treatment-related purposes.

Client Email (14 & older): _____@_____
OR
Parent Email (if client under age14): _____@_____

- ____Yes ____No For EAP Satisfaction **Survey** ONLY
- ____Yes ____No For Monthly EAP **Electronic Newsletter**
- ____Yes ____No For **other** treatment-related purposes

If you would like to receive our one time Survey, Monthly Newsletter and agree to use your email for other Treatment–related purposes, you must check off **YES** in the spaces provided above. If you do not agree to use your email- please check **NO**

Home Telephone ____Yes ____No # _____ OK to Leave Message ___

Work Telephone ____Yes ____No # _____ OK to Leave Message ___

Cell Phone ____Yes ____No # _____ OK to Leave Message ___

Please list below the names of people authorized to receive information about my care:

Spouse: _____ Phone# _____

Parent: _____ Phone# _____

Other: _____ Phone# _____

Who may we contact in case of an emergency?

Name: _____ Relationship: _____ Phone Number: _____

Client Signature: _____ Date: _____
(14 years and older)

Parent/Guardian Signature): _____ Date: _____
(If client under age 14)

EAP Witness Name: _____

EAP Witness Signature: _____ Date: _____