Elyse Einhorn LCSW LLC

Child & Adolescent Psychotherapy

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Request for Confidential Handling of Health Information

I, _____ request that
(Patient's First and Last Name)
Elyse Einhorn LCSW LLC handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please check and list all means by which you prefer to receive your health information.

- ☐ Home Telephone: _____
- ☐ Cellular Phone: _____
- ☐ Work Telephone:_____
- ☐ Fax: _____
- ☐ Email: _____
- ☐ Postal Service and/or other carrier (UPS, FedEx, et.al.)
- ☐ Other (please list below)

_____

_____

_____

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).

Attention:_____

_____
Street Address

_____ _____ _____
City State Zip Code

C. Additionally, I understand that there may be times when I may provide my therapist with additional means for communication, outside of those listed above. It will be understood that these too will be considered patient authorized confidential communications.

_____ _____
Signature Date

_____
Print Name

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.