Communication Preference Form

Client Name: _____ Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to me such as clinical documentation, appointment reminders, therapy updates etc. I hereby grant permission to STAG to do the following:

Written Documentation and Verbal Information

☐ I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email provided.

☐ I grant permission to provide me with written communication via unencrypted email service. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

☐ I grant permission to provide me with written communication via USPS in an unmarked envelope.

☐ I elect to receive clinical information in person or via telephone through the number provided.

☐ I grant permission to leave relevant medical information on my answering machine or voicemail. I also give permission to release medical information pertaining to the client to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Client	Email Address and/or Phone Number
1.		
2.		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as, to revoke this authorization at any time.

_____ _____

Print Name of Client Date

_____ _____

Signature of Client or Legal Representative Relationship to Client