



COMMUNICATION AUTHORIZATION

First name: _____ Middle initial: _____ Last name: _____

In order to protect your privacy your written permission is required to communicate protected health information (PHI) regarding your treatment with you or other individuals that you authorize.

Please choose one of the following:

I DO CONSENT for my healthcare provider to leave detailed messages regarding my personal health information (PHI) using the following options:

Permission to leave message at home #:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Permission to leave message at work #:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Permission to leave message at mobile #:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May correspond via text message at mobile #:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May correspond via email at email address:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
May leave message with family/other contact:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

This will remain in effect for one year from this date until you rescind it in writing: _____

I DO NOT CONSENT for my provider to leave any detailed message on phone, e-mail or text message

I DO NOT CONSENT for my provider to communicate messages regarding my personal health information (PHI) to family members.

REVOCATION OF PRIOR CONSENT: I wish to rescind or stop any prior consent to leave detailed messages or communicate with family regarding my personal health information (PHI).

I acknowledge that Resilient Hearts, LLC cannot guarantee that any information sent via e-mail or text message remains confidential. I understand that text messages and e-mail should never be used for emergency communication. I understand that Resilient Hearts, LLC staff may use these methods of communication for messages unless I provide written notification to revoke authorization for one or more of them. I will notify Resilient Hearts, LLC if any of the contact information listed above changes.

Client/Guardian Name Printed

Client/Guardian Signature

Date