Client Consent Form
Use and Disclosure of Protected Health Information

SECTION I: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL

Addiction Connections Resource's staff routinely is unable to contact clients directly, especially for follow up information. On these occasions our office leaves messages on communication devices provided by our patients. Due to new federally mandated HIPPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: the name of our organization, request to return call, resource or treatment information.

_____ (Initial) I agree to allow Addiction Connections Resource's staff to leave messages on all three communication devices: home, work and cell phone.

_____ (Initial) I agree to allow Addiction Connections Resource's staff to leave messages on the following: **Please initial** the applicable communication devices:

____ **Home** Number _____ ____**Cell** Number _____

____**Other** Number _____

_____ (Initial) No, I do not agree to allow Addiction Connections Resource's staff to leave messages that include Protected Healthcare Information on my home, cell or any other communication device.

SECTION II: PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED TO ACCESS PROTECTED HEALTH CARE INFORMATION TO BE USED AND/OR DISCLOSED

Addiction Connections Resource's staff routinely is unable to contact clients directly, especially for follow up information. On these occasions, it would support us in gathering information if we could speak to an authorized entity. The information we collect assists us in raising funds to help others.

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or disclose your protected health information regarding treatment, payment, other healthcare operations and follow up information.

_____

Name of Authorized Person or Entity Relationship Phone Number

_____

Name of Authorized Person or Entity Relationship Phone Number

_____ _____

Client's Printed Name **Client's Signature** Date