COMMUNICATION REQUEST FORM

Under the Health Insurance Portability and Accountability Act (HIPAA), you have a right to request that we communicate with you in a particular way and in a particular place to protect confidentiality of your medical information. Please check below any methods and places we may contact you.

Please print or type all information other than the signature.

I hereby authorize Jeff Schultz, LPC, CSAT or Francesca Schultz, MC, LPC of the Sonoran Healing Center, LLC and / or any designated business associates to contact me in the following way(s) and at the following location(s):

> By mail at: _____

Specific instructions (no return address on envelope, stamped *Confidential* etc.) _____

_____

> Home Phone at: _____

Specific instructions (leave first name only, leave phone number only etc.) _____

_____

> Work Phone at: _____

Specific instructions (leave first name only, leave phone number only etc.) _____

_____

> Cell Phone at: _____

Specific instructions (leave first name only, leave phone number only etc.) _____

_____

> **Email Address** at: _____

Specific instructions _____

_____ _____ _____ _____

Signature of Client Date Witness Date