

# Choices Counseling & Resource Center, P.A.

## Request for Alternative Means of Confidential Information

The purpose of this form is to request alternative means of Choices Counseling & Resource Center, P.A. providing confidential communication to the client.

Client

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Your relationship to client:  Self  Parent/legal guardian  Legal representative  
 Other (describe) \_\_\_\_\_

Check those which apply:

Alternative address. Send client communication material to

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternative phone. Make phone calls to

Phone: \_\_\_\_\_

I authorize the above request.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/guardian/legal representative (if applicable)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness (if client is unable to sign)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_