The Counseling Center of Wayne and Holmes Counties

Request to Restrict Confidential Communication

SECTION A: Client to complete the following information.

NAME: _____ BIRTH DATE: _____

ADDRESS: _____

TELEPHONE: _____ DATE: _____

I hereby request to receive confidential communications from The Counseling Center regarding my health condition, care, treatment, services, and/or payment in the following alternative manner and method **(check all that apply)**:

- ☐ At a telephone number other than the number listed in the record. The new telephone number is: _____.
- ☐ At a mailing address other than the address listed in the record. The new mailing address is: _____ _____.
- ☐ Via e-mail, the address is: _____.
- ☐ Other. Please specify: _____.

I understand that, if The Counseling Center agrees to provide me with confidential communications regarding the health care of the individual named via the above-identified alternative manner and method, The Center may condition agreement upon the following:

a. The receipt of information from me as to how payment for The Counseling Center's services will be handled.
b. The specification of an alternative address or other method of contact.

Client Signature _____ Date_____

Parent/Guardian Signature _____ Date_____

SECTION B: The Counseling Center to complete the following.

The above request regarding confidential communications via an alternative manner and method has been reviewed by The Counseling Center and has been:

☐ Accepted ☐ Denied (The Center cannot reasonably accommodate request.)

Comments:

_____ _____

Diane S. DeRue, MPA, LSW Date
Compliance and Privacy Officer

Client Name _____ Case Number_____
cc: Medical Records
DSD (01/03) (Rev. 04/04)
(QA 11/04)