PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Phone
  - ○ Leave message with detailed information
  - ○ Leave message with call back number only
- ☐ Work Phone
  - ○ Leave message with detailed information
  - ○ Leave message with call back number only
- ☐ Written Communications
  - ○ Mail to my home address
  - ○ Mail to my work/office address
  - ○ Fax to (_____)_____

_____ _____

Print Name Date

_____

Signature

☐ I acknowledge the receipt of the Notice of Privacy Practices form.