**VALDOSTA PSYCHIATRIC ASSOCIATES, LLC**

## CONSENT FOR COMMUNICATION

Most patient have family members and friends that occasionally become involved in their care. For example, your spouse calls to confirm your appointment time; **OR** your adult child calls with questions about your medication; **OR** a friend, who helps you, calls because they are concerned about you. You have a right to request that we restrict how protected health information about you is used or disclosed.

**If you have anyone that you would allow us to communicate with, please list them below**. Due to privacy regulations, we cannot speak to anyone but the patient unless we have your written permission.

**I give Valdosta Psychiatric Associates staff my permission to speak with the following individuals regarding my care: (If you prefer that we not speak with ANYONE, please write NO One across the lines)**

| **Name of Family or Friend** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Restrictions to Communications**:_____
_____

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I request that all communications (by telephone, mail or otherwise) by Valdosta Psychiatric Associates and/or its staff be handled in the following manner:

* For written Communications Address to:_____
_____
_____

* For oral Communications Call: _____
(telephone number)

May we leave a message? Yes ☐
No ☐

I understand that I have the right to revoke this authorization **in writing** at any time. I request that my confidential information be handled in the following manner and authorize Valdosta Psychiatric Associates staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

_____ _____
*Signature of Patient /Legal Guardian* (Minors 12-17 must sign) Date

_____ _____
VPA Staff