

**Robyn E. Brickel, M.A., LMFT, LLC**  
**Confidential Communications Request form**

You have the right under the HIPPA guidelines to request the type of confidential communications you would like to have with Robyn E. Brickel, M.A., LMFT, LLC. To help us get your healthcare information to you in a timely and efficient manner we need you to complete this form identifying your wishes. We will accommodate reasonable requests. As always, Robyn E. Brickel, M.A., LMFT, LLC is dedicated to maintaining the privacy of your health care information.

**Please initial all that apply:**

Will you authorize Robyn E. Brickel, M.A., LMFT, LLC or its representative to leave a message on your phone answering system giving the name Robyn E. Brickel, M.A., LMFT, LLC as who is calling, the phone number and a brief description of why we are calling?

\*I authorize you to leave this type of message:

At my home number: **Initials:** \_\_\_\_\_ On my cell phone number: **Initials:** \_\_\_\_\_

At my work number: **Initials:** \_\_\_\_\_ Do not leave a message: **Initials:** \_\_\_\_\_

In the event that a Robyn E. Brickel, M.A., LMFT, LLC representative would need to leave a more involved message including detailed Protected Health Information (PHI), will you authorize leaving a message with PHI on your phone answering system?

\*I authorize you to leave this type of message:

At my home number: **Initials:** \_\_\_\_\_ On my cell phone number: **Initials:** \_\_\_\_\_

At my work number: **Initials:** \_\_\_\_\_ Do not leave a message: **Initials:** \_\_\_\_\_

In the event that Robyn E. Brickel, M.A., LMFT, LLC would need to email or respond to your email, will you authorize Robyn E. Brickel, M.A., LMFT, LLC representative to send PHI on your email address listed below:

\*I authorize you to leave PHI information on my email address below:

\_\_\_\_\_ Initials: \_\_\_\_\_

\*I understand that I may request PHI to be faxed at my request. I understand that this request must be made in writing. I authorize my PHI to be faxed to the following number:

Fax number: \_\_\_\_\_ Initials: \_\_\_\_\_

\*I authorize you to send PHI via regular mail. Initials: \_\_\_\_\_

I understand that if I do not initial this I will be charged for certified return receipt requested postage when PHI is mailed to me.

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

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

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Signature: \_\_\_\_\_