VALENCIA RELATIONSHIP INSTITUTE
28494 Westinghouse Pl. * Ste 213 * Valencia, CA 91355

Record of Patient Disclosures

In order to best insure your privacy and meet stated HIPPA guidelines, please let me know how to best contact you with any information I need to relay via telephone, email, fax or otherwise.

I prefer to be contacted in the following manner (check all that applies):

Home Telephone ____________________
___ Okay to leave message with the detailed information
___ Leave message with call back information only

Cell Phone ____________________
___ Okay to leave message with the detailed information
___ Leave message with the call back information only

Email ___________________________________
___ Okay to leave message with the detailed information
___ Leave message with the call back information only

Written Communication
___ Okay to mail to my current address
___ Okay to fax detailed information to this fax number__________________

Other ____
____

Patient Signature (Parent signature if patient is a minor) ______________________________
Print name _________________________________
Patient's birth date _________________

Responsible Party Signature ____________________________________
Print name _________________________________
Relationship to Patient __________________________
Date ______, 201_