Montana City Counseling

Communication Limitation

Understanding that my medical records are completely confidential and highly protected, I have been given the following choices with regard to disseminating information to persons of interest.

(*If engaged in couples or family work, add appropriate names and relationships. Add Name of Emergency Contact here as well.)*

I request the following: (Please initial any/all that apply)

_____ (initial) I authorize complete communication with _____ who is my (relationship) _____.

_____ (initial) I authorize limited communication with _____ who is my (relationship) _____, which is limited to:_____ _____ _____.

_____ (initial) I do not wish any information to be conveyed to anyone other than myself. I understand that this authorization is revocable by me at any time. Further this form is valid until revoked by me.

Signature: _____ Date: _____