

## Session Information

**Client:** \_\_\_\_\_  
**Staff:** \_\_\_\_\_  
**Document Date:** \_\_\_\_\_  
**Client Program:** \_\_\_\_\_

## Consent For Contact V4

### CONTACT PREFERENCE

There may be times when we need to contact you regarding your services here at our agency. As a precaution to protect your privacy, we would like to know the best method for communicating with you.

**I prefer to be contacted by:**

(check all that apply)

- Email                       Telephone                       Text message  
 Mailed letter

I understand that text messaging and email are not secure means of communication and may compromise my confidentiality. Text messaging rates may apply. I understand that it is the Agency's policy to utilize these methods of communication at a minimum such as appointment reminders.

I understand that land lines and cell phone communication may not be completely secure and confidential. There is a possibility that someone could overhear or intercept my conversations.

### CONTACT INFORMATION

**Primary telephone #:** \_\_\_\_\_

- Type of phone:**     Cell                       Home                       Work  
                              Family/friend            Other

**Telephone #2:** \_\_\_\_\_

- Type of phone:**     Cell                       Home                       Work  
                              Family/friend            Other

**Email address:** \_\_\_\_\_

**Would you like to receive reminder calls or messages regarding your appointments?**

- Yes  
 No

**If we are unable to speak to you, is it okay that we leave a message?**

- Yes  
 No

**Comments / Additional Instructions:**

\_\_\_\_\_

### CONSENT

By signing this document, I am giving permission to be contacted by the method (s) indicated above. I have the right to change the preferred method of contact and may do so by informing a clerical support staff worker at this agency. I am responsible for keeping the agency updated with current contact information.

### Consent to share medical information

**Sharing partner Authorization/Consent**

Vital \_\_\_\_\_

Gateway Behavioral Health Services  
- Call Reminder Consent

Yes

No

**Provided By**  
**Authorization/Consent on**  
**file**

(Not specified)

By selecting this option,  
you are confirming that  
paperwork was provided  
to the authorizing subject

**Consent Period**

to

### Signatures

**Signature:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_