

# PsychArizona

*Dr. Tammy Martin-Causey*  
*Licensed Psychologist*

*Dr. James Schlichting*  
*Psychology Intern*

Date \_\_\_\_\_ Referred By \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Are you a Medicare recipient? Yes(  ) No(  )

The HIPAA privacy rule gives you the right to request a restriction on uses and disclosures of your protected health information (PHI). You also have the right to request confidential communications or that a PHI communication be made by alternative means, such as sending information to your office instead of home. Information sent via email is not confidential or secure.

I wish to be contacted in the following manner (list only those that apply):

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

(  ) ok to leave a message

(  ) ok to leave message

Work Phone \_\_\_\_\_ Email \_\_\_\_\_

(  ) ok to leave message

Fax \_\_\_\_\_

OK to mail to the following address: \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

You may contact me according to what I have listed above. I understand that confidentiality cannot be insured with email.

Signature \_\_\_\_\_