Interplay
Counseling Services

Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, _____ [Insert Name of Patient/Client], authorize Interplay Counseling Services to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Interplay Counseling Services. Such conversation shall be documented by Interplay Counseling Services.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Interplay Counseling Services.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

_____

Staff Witness to signature Date