

**Lake-Cook Behavioral Health Resources**

**INSTRUCTIONS FOR HANDLING CONFIDENTIAL HEALTH INFORMATION**

**Patient Name:** \_\_\_\_\_

Do you have any concerns about members of your household knowing that you are receiving behavioral health care services from Lake-Cook Behavioral Health Resources?

\_\_\_\_\_ No

\_\_\_\_\_ Yes. Please describe; \_\_\_\_\_  
\_\_\_\_\_

Telephone Contact: (Check all that apply)

\_\_\_ Lake-Cook staff may identify themselves to members of your household. For example, "This is Dr. Smith's office" or "This is Jane Jones from Lake-Cook Behavioral Health."

\_\_\_ Lake-Cook staff may leave a message containing identifying information with household members or on your home answering device regarding business matters or appointment scheduling.

\_\_\_ Lake-Cook staff may leave a message containing identifying information on your cell phone service.

\_\_\_ Lake-Cook staff may leave a message containing identifying information on your private voice mail at work.

Correspondence: (Check preferred address)

\_\_\_ All correspondence should be sent to my home address.

\_\_\_ All correspondence should be sent to the following address:  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_ I do not want any correspondence sent to me. You must discuss an alternate means of delivering information to me.

\_\_\_ I hereby acknowledge receipt of Lake-Cook Behavioral Health Resources Notice of Policies and Procedures to Protect the Privacy of Your Health Information.

Signature: \_\_\_\_\_  
(Patient/Parent/Guardian)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_