3200 Tower Oaks Blvd., Suite 200 Rockville, MD 20852 Phone: 301-593-6554 Fax: 301-255-0461
8401 Connecticut Ave., Suite 1120, Chevy Chase, MD 20815 Phone: 301-593-6554 Fax: 301-754-1034

Confidential Handling of Health Information for Minor

All reasonable requests to communicate with you and to convey health information, as well as billing information, using your preferred methods, will be accommodated. Please check and list **ALL** methods by which you approve receiving your health and/or billing information.

On behalf of____, I/we request that
(First and Last Name of Minor)
Alvord, Baker & Associates, LLC handle confidential health information in the following way(s):

Parent/Guardian 1	**Parent/Guardian 2**
Name: ____________________	Name: ____________________
Call me at the following number(s):	**Call me at the following number(s):**
Home ____________________	Home ____________________
Cell ____________________	Cell ____________________
Work ____________________	Work ____________________
Fax me at____________________	**Fax me at**____________________
Email me at____________________	**Email me at**____________________
Send to the following address:	**Send to the following address:**
____________________ **Street**	____________________ **Street**
____________________ **City, State, Zip**	____________________ **City, State, Zip**

Parent/Guardian 1

I understand that there may be times when I may provide my therapist with additional means for communication, outside of those listed above. It will be understood that these too will be considered patient authorized confidential communications.

____ _ ____________________
Parent/Guardian Signature 1 Date

____
Print Name

____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Parent/Guardian 2

I understand that there may be times when I may provide my therapist with additional means for communication, outside of those listed above. It will be understood that these too will be considered patient authorized confidential communications.

____ ________________________

Parent/Guardian Signature 2 Date

____

Print Name

____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.