**Stepping Stone Retreat for Enhanced Living, LLC**

**William R. Boyd, JR., Ph.D.**

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**RELEASE OF PROTECTED HEALTH INFORMATION**

**I have read and fully understand the Notice of Privacy Practices for Protected Health Information (PHI) offered by Dr. Bill Boyd and Stepping Stone Retreat for Enhanced Living, LLC. In general, HIPAA privacy rules give the right to request a restriction, or release of certain restrictions regarding the use and disclosures of protected health information (PHI). An individual may also request alternate means of correspondence for confidential and protected health information. Please check all that apply below.**

* **Home Phone**
* May leave messages with detailed information
* Leave message with call back number only
* May leave message with family member, or other person (see below)
* **Work Phone**
* May leave message with detailed information
* Leave message with call back number only
* **Written Communication**
* May mail to home
* May mail to office
* May fax to this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* May text to this number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **I authorize the release of my PHI and medical information to the following:**

*Name Relationship to Patient*

*Patient Signature Date*