

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

I, _____, authorize Four Elements Integrative Counseling to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Four Elements Integrative Counseling. Such conversation shall be documented by Four Elements Integrative Counseling.

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 Four Elements Integrative Counseling.

Signature of Patient/Client Date

Signature of Parent, Guardian or Personal Representative Date