



PATIENT RECORD OF DISCLOSURE

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information. The individual is also granted the right to request confidential communications, or that a communication is made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

_____ By home telephone, my number is _____

_____ It is ok to leave a message with detailed information.

_____ It is NOT ok to leave me a message with detailed information.

_____ It is ok to contact me at my work telephone number, which is _____

_____ It is ok to leave me a detailed voice message at my work number.

_____ It is NOT ok to leave me a detailed voice message at my work number.

_____ It is ok to leave a call back number only at my work.

I AUTHORIZE YOU TO DISCUSS MY MEDICAL HISTORY AND RELEASE ANY AND ALL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS:

(Fill in all that apply)

_____ My spouse, whose name is: _____ phone _____

_____ My parent, whose name is: _____ phone _____

_____ No one other than myself.

_____ Other, name: _____ phone _____

Relationship to patient _____

Patient Signature _____ Date _____

Printed Name _____

Date of Birth _____

Name of legal guardian/caretaker _____

Physician _____