**PATIENT RECORD OF DISCLOSURES**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home.

**Preferred Contact Method** (Please check only one):

**□** Home Phone **□** Written Communication **□** Work Phone **□** Cell Phone **□** Email Address

**I Wish to Be Contacted in the Following Manner** (please check all that apply):

\_\_ **Home Telephone** \_\_**Written Communication**

 \_\_ Okay to leave voicemail \_\_Okay to mail to my home address

 \_\_ Okay to leave message with another person \_\_Okay to mail to my work/office address

 Best time to call: □ Morning □ Afternoon □ Evening \_\_Okay to fax to this number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ **Work Telephone** \_\_ **Cell Phone**

 \_\_Okay to leave voicemail \_\_Okay to leave voicemail

 \_\_Okay to leave message with another person \_\_Okay to leave message with another person

Best time to call: □ Morning □ Afternoon □ Evening \_\_Okay to send text appointment confirmations\*

\_\_**E-mail address** \*Cell Phone Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Okay to send e-mail appointment confirmations *(Required for text reminders)*

 or patient communication. Best time to call: □ Morning □ Afternoon □ Evening

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. ***NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency***.

**AUTHORIZATION FOR DISCLOSURE:** I give express permission to discuss with the individual(s) I have listed:

Please check the appropriate box(es)

|  |  |  |
| --- | --- | --- |
|  **Any aspect of my Health Care** |  **Health information only** |  **Financial information only** |

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name Relationship Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_