## PATIENT RECORD OF DISCLOSURE

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 communications of PHI be made by alternative means.

I wish to be contacted in the following manner (check all that apply):

**Home Telephone:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

**Written Communication:**

- ☐ O.K. to mail to my home address and/or email address.
- ☐ O.K. to mail to my work/office address.
- ☐ O.K. to address: _____ (name)

**Work Telephone:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

**Cell Phone/Other:** _____

- ☐ O.K. to leave message with detailed information.
- ☐ Leave message with call-back number only.
- ☐ O.K. to speak to: _____

Please complete the following to give your authorization for our office to speak with anyone other than yourself regarding your medical care. If left blank I understand that no one other than me (patient) will have the authority to speak with our offices regarding my medical care.

Print Name _____ Relationship _____

Print Name _____ Relationship _____

Please initial:

_____ I have received the "Notice of Privacy Practices" for this office.

By signing below, I acknowledge that I have read and agreed to all the above information:

Patient's Name _____ Date _____

Patient Signature _____