DISCLOSURE OF PATIENT PROTECTED HEALTH INFORMATION (PHI)

In general, the HIPAA privacy act 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 alternate means, such as sending correspondence to the individual's office instead of the individual's home.

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

Telephone

Leave a detailed message at home	Yes	No
Leave a call back number at home	Yes	No
Leave a detailed message on my cell phone	Yes	No
Leave a detailed message at work phone	Yes	No

Written Communication

OK to mail to my home address	Yes	No
OK to leave a detailed text message on my cell phone	Yes	No
OK to e-mail to _____	Yes	No
OK to fax to (____) _____	Yes	No

Authorized PHI Recipients

Spouse _____	Yes	No
Child _____	Yes	No
Parent _____	Yes	No
Other _____	Yes	No

Please provide your signature to indicate that you have read the HIPAA Notice posted in our office as well as the Office Policy Guidelines provided for your review. Your signature also indicates your agreement to follow the HIPAA policies established here.

_____ _____

Patient Name (please print) Date

_____ _____

Patient or Responsible Party Signature Date