Patient Disclosure Form

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.

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

- ☐ Home Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Work Telephone
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to number indicated
- ☐ _____
- ☐ Other (Fax/Cell, etc.) _____

I allow you to discuss my clinical information, or answer questions in regards to my patient account, with the following person(s) (Check all that apply)

- ☐ Spouse _____
- ☐ Parent _____
- ☐ Child _____
- ☐ Other (specify) _____
- ☐ None

_____

Patient or Parent/Guardian Signature Today's Date

_____

Patient Name (Print) Patient Birth Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have viewed and had an opportunity to receive a copy of this office's Notice of Privacy Practices.

_____

Print Name Signature

_____

Date