CARDIOLOGY SPECIALISTS
of Orange County

Patient Contact Information Restriction

For the office(s) of:

Medical Group/Physician Name**: Cardiology Specialists of Orange County**_____

Address: _____

Phone number: _____

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 alternative means of communicating PHI, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (**please 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_____
- Other_____

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be in effect until which time it is revoked.

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Birth Date**