Patient Contact Information Restriction

For the office(s) of:

WOMEN'S CARE OF BEVERLY HILLS MEDICAL GROUP
8920 Wilshire Blvd., Suite 511
Beverly Hills, CA 90211
310-657-1600

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
- **Mobile Phone**_____
- Ok to send Text Message for Appointment Reminder
- Ok to leave Voice Message with detailed information
- **Work Telephone**_____
- OK to leave message with detailed information
- Leave Message with call back number only
- **Email** _____
- OK to Email Appointment Reminder messages
- **Mail/Fax Options**
- 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

_____

_____

_____

PATIENT SIGNATURE

_____

Print Name _____

Date:_____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse_____(initial) HIV Diagnosis/Treatment _____(initial)

Psychiatric/Mental Health _____(initial) Genetic Information _____(initial)

Tests for Antibodies to HIV _____(initial)

DURATION This authorization shall be effective immediately and remain in effect until_____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness name Witness signature

Rev Oct 2013