PATIENT REQUEST FOR SPECIAL PRIVACY DISCLOSURES and or COMMUNICATION THROUGH CONFIDENTIAL CHANNELS

The HIPAA privacy rule of 1996, gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI), with respect to treatment, payment and health care operations. You also have the right to request that we restrict disclosure of information to members your family and other relatives or personal friends and or that all communications be made through confidential channels. **Woodglen** will make reasonable efforts to accommodate all reasonable requests. **Some method of contact must be provided.**

I, (PRINT NAME)

_____

Hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

Telephone

I want you to contact me by telephone at:

(____)_____

☐ Do ☐ Do not leave messages on my answering machine.

☐ Do ☐ Do not leave messages with any other person.

Mail

I want you to contact me at the following address:

_____

_____

Fax

I want you to contact me at the following fax number:

(____) _____

Other_____

✻✻✻✻✻✻✻✻✻✻✻✻✻✻

☐ I **do not** want my health information used or disclosed for any of the following **purposes;**

_____

_____

☐ I **do not** want my health information to be disclosed to an of the following **people**;

_____

_____

✻✻✻✻✻✻✻✻✻✻✻✻✻✻

DISCLOSURE AUTHORIZATION

I hereby authorize the use /disclosure of my health information as described below. I understand this authorization is voluntary and that **ALL OF MY RECORDS ARE CONFIDENTIAL AND CANNOT BE DIS-CLOSED WITHOUT MY PRIOR WRITTEN AUTHORIZATION.** A photocopy or fax of this document is as valid as the original.

Patient name _____

Date of Birth: _____

Person(s) / organizations authorized to use/disclose information: **WOODGLEN MEDICAL GROUP**

Person(s) /organizations authorized to receive the information: _____

_____ _____

_____ _____

_____

SIGNATURE OF PATIENT OR REPRESENTATIVE

TODAY'S DATE ___/___/___

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient

☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased