

Disclosure of Patient Protected Health Information

In general, the HIPPA 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 at work	Yes	No
Leave a detailed message on cell phone	Yes	No

Written Communication

Ok to mail it to my home	Yes	No
Ok to mail to my work/office	Yes	No
Ok to fax to this number () - _____	Yes	No

Authorized PHI Recipients

Spouse	Yes	No
Parent	Yes	No
Child	Yes	No
Other (Relationship)	Yes	No

We ask that you sign your name in the space provided to indicate that you have read the HIPPA Notice posted in your office as well as the Office Policy Guidelines provided for your review. Your signature indicates your agreement to follow the HIPPA polices established here.

Patient or Responsible Party

Signature

Date