PATIENT RECORD OF DISCLOSURE

IN GENERAL, THE HIPAA PRIVACY RULE GIVES PATIENT THE RIGHT TO REQUEST USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE PATIENT IS ALSO PROVIDED THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT 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):

_____ CELL PHONE____
_____ HOME PHONE ____
_____ WORK PHONE____
____ EMAIL ADDRESS______________________@___________.COM / NET
_____ LEAVE MESSAGE WITH DETAILED INFORMATION
_____ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK INFORMATION ONLY
_____ LEAVE DETAILED MESSAGE ON WORK, CELL, HOME VOICEMAIL ONLY (PLEASE CIRCLE)
_____ WHEN UNABLE TO CONTACT ME BY PHONE, A WRITTEN COMMUNICATION MAY BE SENT TO MY HOME ADDRESS
_____ OTHER ____

I, __________________________ CONSENT AND AUTHORIZE THE RELEASE OF ANY (PLEASE CIRCLE) NORMAL / ABNORMAL TEST RESULTS TO THE FOLLOWING PERSONS:

____
(PRINT NAME) (RELATIONSHIP) (PHONE NUMBER)

____
(PRINT NAME) (RELATIONSHIP) (PHONE NUMBER)

____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

____
DATE

I, ______________________________ CONSENT AND AUTHORIZE THE RELEASE OF APPOINTMENT INFORMATION (DATE & TIME) AND ALLOW FOR APPOINTMENT SCHEDULING ON MY BEHALF TO THE FOLLOWING PERSONS:

____

(PRINT NAME) (RELATIONSHIP) (PHONE NUMBER)

____

(PRINT NAME) (RELATIONSHIP) (PHONE NUMBER)

I, ____________________________ CONSENT AND AUTHORIZE THE RELEASE OF BILLING INFORMATION AND PAYMENT'S MADE ON MY BEHALF TO THE FOLLOWING PERSONS:

____

(PRINT NAME) (RELATIONSHIP) (PHONE NUMBER)

HEALTHCARE PROVIDERS MUST KEEP RECORDS OF PHI DISCLOSURES. INFORMATION PROVIDED WILL BE DOCUMENTED IN OUR ELECTRONIC PATIENT HEALTH INFORMATION (e-PHI)

____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

____

DATE

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I HAVE RECEIVED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE

____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

____

DATE OF BIRTH SOCIAL SECURITY NUMBER

____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_______ (INITIAL) I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THESE AUTHORIZATION FORMS, IN WRITING, AT ANY TIME.

______(INITIAL) I UNDERSTAND THAT THE INFORMATION PROVIDED IN THIS AUTHORIZATION FORM EXPIRES TWO YEARS FROM THE DATE OF SIGNATURE.