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.

PREFERRED METHOD OF CONTACT: _____CALL _____TEXT ____EMAIL

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

_____ VIA TEXT MESSAGE
_____ LEAVE MESSAGE WITH DETAILED INFORMATION
_____ LEAVE MESSAGE WITH NAME/DOCTOR & CALL BACK INFORMATION ONLY
_____ OTHER _____

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

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

_____
(THEIR NAME) (RELATIONSHIP) (PHONE NUMBER)

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

_____
(THEIR NAME) (RELATIONSHIP) (PHONE NUMBER)

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

(THEIR 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

DATE OF BIRTH

SIGNATURE OF PATIENT 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.