



PATIENT DISCLOSURE INSTRUCTIONS

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 that a 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)**:

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Cell phone _____ |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to leave message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Leave message with call-back number only |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detail information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to fax to number indicated _____ |
| <input type="checkbox"/> O.K. to email _____ | |

I allow you to give clinical information or answer questions from **(check all that apply)**:

- Spouse _____
- Parent _____
- Child _____
- Other (specify): _____

I allow the specified person(s) to make, change or cancel my appointments:

- I do allow I do not allow

Patient Signature

Date

Print Name

Birth date