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 individuals office instead of the individuals home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____
- ☐O.K. to leave a message with detailed information
- ☐Leave message with call-back number only

☐ Written Communication
- ☐O.K. to mail to my home address
- ☐O.K. to mail to my work/office location
- ☐O.K. to fax to this number

☐ Cell Telephone_____
- ☐O.K. to leave message with detailed information
- ☐Leave message with a call-back number only

☐ SS#_____

Email Address:_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record.
NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check the box if the disclosure is authorized
(2) Type key: T=Treatment Records P= Payment Information O= Healthcare Operations
(3) Enter how disclosure was made: F= Fax P= Phone E= Email M= Mail O= Other

Release of Information Request

By witness of my signature, I hereby give permission to my insurance company and/or physician to release information regarding my benefits or medical records.

Signature of Patient:_____ Date:_____