

PATIENT RECORD OF DISCLOSURE

Patient Name: _____

DOB: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communication or that a communication of HI 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):

- Home Telephone _____ or Cell _____
 - OK to leave message with detailed information regarding my child.
 - OK to leave message with call back number only.

- Written Communication
 - OK to mail to my home address.
 - OK to mail to my work/office.
 - OK to fax to this number _____

- Work telephone _____
 - OK to leave a message with detailed information
 - Leave message with call back number only.

- Text Messages **(at this time we are not using this method but may in the future)**
 - OK to leave a detailed text message regarding my child.

- Email Messages **(at this time we are not using this method but many in the future)**
 - Ok to send email with detailed message regarding my child.

Email Address: _____

Patient / Parent / Guardian Signature

Date

Print Name

Relationship to Patient

Note: Please notify our office should any of the above communication information change. Thank you