Patient Authorization of Disclosure

In general, HIPPA Privacy Rules 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 of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Patient may revoke or change this authorization at any time with a written request.

Part 1

I wish to be contacted in the following manner (Mark all that apply):
Patient Name: ___________________

Home Telephone: ___________________
___ OK to leave message with detailed information
___ Leave message with call-back number only

Work Telephone: ___________________
___ Ok to leave message with detailed information
___ Leave message with call-back number only
___ Do not call me at work

Cell Telephone: ______________________
___ Ok to leave message with detailed information
___ Leave message with call-back number only
___ Do not call me at my cell phone

Patient/Guardian Signature: __________________________ Date: ___________

Part 2

In a further effort to protect year health information and the confidentiality of your healthcare, we ask that you designate below to whom the physicians and staff may discuss your healthcare and scheduling needs as well as billing issues that may arise.

___ Only disclose information to myself

Name	Relationship	Phone Number(s)

Patient/Guardian Signature: ______________________ Date: __________