Patient Authorization for Disclosure & Communication Preferences

Under the HIPAA Privacy Rule, individuals have the right to request restrictions on how their Protected Health Information (PHI) is used and disclosed. Individuals also have the right to request confidential communications of PHI by alternative means or at alternative locations. This authorization may be revoked or modified at any time by submitting a written request.

Preferred Method(s) of Contact (Please mark all that apply):

Home Telephone: _____

☐ OK to leave a message with detailed information

☐ Leave a message with call-back number only

☐ Do not contact me on this number

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Work Telephone: _____

☐ OK to leave a message with detailed information

☐ Leave a message with call-back number only

☐ Do not contact me on this number

Mobile Telephone: _____

☐ OK to leave a message with detailed information

☐ Leave a message with call-back number only

☐ Do not contact me on this number

Email Address: _____

☐ OK to communicate with me via email

☐ Do not contact me via email

Authorization to Discuss Health Information

To further protect your privacy, please indicate below who our physicians and staff may communicate with regarding healthcare, scheduling, and billing matters.

☐ Only disclose information to me

Acknowledgment & Signature

I acknowledge that I have read and understand this Patient Authorization for Disclosure & Communication Preferences. I understand that I may revoke or modify this authorization at any time by submitting a written request.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

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If signed by a Guardian:

Name of Guardian (Printed): _____

Relationship to Patient: _____

Signature of Guardian: _____

Date: _____