

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA 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"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> O.K. to mail to my work/office address
<input type="checkbox"/> O.K. to fax this number _____ |
| <input type="checkbox"/> Work Telephone: _____
<input type="checkbox"/> O.K. to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Other: _____
_____ |

Parent Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests 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 requested by the individual.

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)

Acknowledgement of Receipt of Notice Of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information: _____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgement, please document the date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____