Family Health, PC

PATIENT RECORD OF DISCLOSURES

Name_____

MR # _____

Date_____

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 require 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 applies):

Home telephone _____

Cell telephone _____

_____OK to leave a voice message to call the office back.

_____ OK to leave a voice message with detailed medical information.

_____ OK to discuss your medical or personal information with:

Spouse_____

Children_____

Other_____

Written Communication

_____OK to mail to my home address

PATIENT WAIVER

Notice of Acknowledgement

I acknowledge that I have received Notice of Privacy Practices.

_____

Patient's signature

If a Personal Representative's signature appears above, please describe relationship to patient.

_____

*As a patient of Family Health PC I grant access to my pharmacy records to obtain refills.

_____

Patient's signature