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## PATIENT DISCLOSURE INSTRUCTIONS

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 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):

### **Home/Cell Phone**

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to fax to number indicated

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### **Written Communication**

- OK to mail to my home address
- OK to mail to my work/office address

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### **Work telephone**

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to fax to number indicated

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### **Other**

- OK to telephone the cell number indicated
- OK to contact me at the e-mail address indicated

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I allow you to give my clinical information to or answer questions from (check all that apply):

- Spouse \_\_\_\_\_
- Parent \_\_\_\_\_
- Child \_\_\_\_\_
- Other \_\_\_\_\_
- None \_\_\_\_\_

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Patient Signature

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Date

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Print Name

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Birth Date