HIPAA Form – Patient Record of Disclosures

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 is made by alternative means, such as sending correspondence to the individuals office instead of their home.

I wish to be contacted in the following way(s): (Please initial all that apply.)

_____ Home telephone (_______) _______ - __________
_____ Leave detailed message _____ Leave call-back number

_____ Cell Phone (_______) ________ - ___________
_____ Leave detailed message _____ Leave call-back number

_____ Work telephone (_______) _______ - _________
_____ Leave detailed message _____ Leave call-back number

_____ Email – Home __________________ @ ____________________________
_____ Send detailed message _____ Send request to call office only

_____ Email – Work __________________ @ ____________________________
_____ Send detailed message _____ Send request to call office only

_____ Postal Mail – Home
Address
____
____
____

_____ Postal Mail – Work
Address
____
____
____

I authorize the following people to receive PHI regarding my treatment:

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

I acknowledge that I have received a copy of the OOC Privacy Practices Notice containing a more complete description of my PHI privacy rights and that I agree to the release of my PHI as indicated above.

____
Name

______________________________ ________________
Signature Date