**HIPAA Privacy**

**I agree / wish to be contacted in the following manner (check all that apply):**

Written Communication

O.K. to mail to mail to my home address

O.K. to mail to my work/office address

Home/Cell Telephone

O.K. to leave message with detailed

Leave message with call-back number

Text Messages

**I agree that my protected health information can be discussed/disclosed to the following person:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Guarantor’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 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.

The Privacy Rule generally requires health care 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 of disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Users and Disclosures for TPO may be permitted without prior consent in an emergency.

**FOR OFFICE USE ONLY**

Record of Disclosures of Protected Health Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date | Disclosed to Whom Address or fax number | (A) | Description of Disclosure/Purpose of Disclosure | By Whom Disclosed | (B) | ( C) |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

A. Check this box if the disclosure is authorized

B. Write in box: T= Treatment records P= Payment Information

C. Enter how disclosure was made: F= Fax P=Phone E=Email M=Mail O=Other