**PATIENT DISCLOSURE INSTRUCTIONS**

**Notice of Privacy**

**Omnibus Rules**

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

**Home Telephone _____**

- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call-back number only

Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave a message with call back number only

Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to _____
- ☐ O.K. to text to cell phone _____
- ☐ O.K to email to _____

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

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

Preferred Pharmacy:

Name: _____

Address: _____

Telephone #: _____

Please initial showing that you understand the following statements.

_____ 1. Our practice does not use your Protected Health Information (PHI) for any fundraising.

_____ 2. We are obligated to notify you (the patient) in the event of a breach of unsecured PHI.

_____ 3. If you pay in full at the time of service, you have the right to request that our office does not disclose your treatment information to a health plan. Please notify us if you do not want your insurance billed.

_____ 4. You have a right to a copy of your health records; as of now we are not currently set-up with the ability to send you electronic records.

Patient Signature (Legal Guardian): _____ Date: _____

Print Name:_____ Birth Date:_____