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 message with call-back number only

☐ Work Telephone _____

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

☐ Written Communication

☐ OK to mail to my home address
☐ OK to mail to my work/office address
☐ OK to fax to number indicated
☐ OK to text to cell phone

☐ Other (Fax/Cell, etc) _____

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

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

_____ 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 our office NOT to disclose your treatment information to a health plan. Yes No

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

_____ _____
Patient Signature (or Legal Guardian) Date

_____ _____
Print Name Birth Date