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PATIENT CONTACT INFORMATION RESTRICTION

HIPAA

Under the HIPAA privacy rule, you have the right to request a restriction on uses and disclosures of your protected health information (PHI), and to request confidential communications or alternative means of communicating PHI — for example, sending correspondence to your office instead of your home.

Patient Name: _____ **DOB:** _____

Please contact me in the following manner (check all that apply):

Home Telephone

- OK 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: _____
- Other: _____

Authorized Individuals

I consent to the release of Protected Health Information to the following individual(s), who may bring my child(ren) for appointments. This authorization remains in effect until revoked.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient / Guardian

Date