

## PATIENT DISCLOSURE PREFERENCES

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

Home phone:

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

Cell phone:

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

Business phone:

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

Written communication:

- Ok to mail correspondence (if needed) to home address

In general, HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of personal health information be made by alternative means.

Name (print) \_\_\_\_\_

DOB \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Who are we allowed to speak to about your health information?

(This includes, but is not limited to, things such as lab results, refills, medical instructions, etc.)

Name	Relationship

- Do not speak with ANYONE regarding my health information.

Who should we contact in case of an emergency?

\_\_\_\_\_ (name) \_\_\_\_\_ (phone)

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