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I, _____**(Patient Name or Parent/Guardian Name if Under 18)**, hereby acknowledge that I have been made aware of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice. I have also been made aware that I may request a copy of this practice's Notice of Privacy Policy at any time.

PATIENT DISCLOSURE INSTRUCTIONS

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.

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

☐ Written Communication

☐ O.K. to mail to my home address
☐ O.K. to mail to my work/office address
☐ O.K. to fax to number indicated

☐ Work Telephone _____ ☐ Other (Fax/Cell, etc.) _____

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

_____

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

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

_____ _____
Patient or Parent/Guardian (if under 18) Signature Date

_____ _____
Print Name Birth date of **PATIENT**

Revised 4/11