La Vista Clinic

PATIENT RECORD OF DISCLOSURES

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 _____
___ 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

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

E-Mail _____
___ ok to e-mail any correspondence(i.e., appt. info)

Person(s) authorized to receive information on you:

_____
Name of Person Relationship

_____
Name of Person Relationship

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment
(please initial) and/or other information pertinent to my healthcare and/or payment for my healthcare.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the
(please initial) patient.

You may revoke or terminate this authorization by submitting a written revocation to us. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

_____
Patient Name (Printed) Date of Birth

_____
Patient Signature (Patient or Authorized Representative) Date

_____
Witness Date