# PATIENT RECORD OF DISCLOSURE

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 require confidential communications or other communications of **PHI** be made by alternative means such as:

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

____ OK to leave message with family member

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

_____ _____ _____

Patient Signature Print Name Date

## Notice and Acknowledgment

Acknowledgment:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

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