Family Foot & Ankle Care
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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.   The individual is also provide the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of their 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 work/office address

   ___O.K. to mail to my home address

   ___O.K. to fax to this number_____

   ___O.K. to e-mail _____

___**Work Telephone** _____

   ___O.K. to leave message with detailed information

   ___Leave message with call-back number only

___**Other** _____

_____

_____   _____

Patient Signature   Date

_____   _____

Name (please print)   Date of Birth

Authorized Representative:

As Per the HIPAA Privacy Act you may authorize a representative to obtain medical information or discuss your condition with the Doctor or doctors' staff. The representative may be identified by supplying us with the 'code word' designated by you.

Code Word: _____ (ex: mother's maiden name)

_____   _____   _____

Representative Name   **Birth Date**   **Phone #**

*This authorization will be effective until the patient revokes this authorization by signing below.

I hereby **revoke** the person listed above as my authorized representative, effective the date of my signature below or other notification in writing.

_____   _____

Patient Signature   Date