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Diplomate, American Board of Orthopedic Surgery
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Patient Record of Disclosures

In general, the HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of *protected health information* (*PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* is 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/circle all that apply**):

Voice Communication (Telephone):

Home #:_____Work #:_____Cell #:_____ Other: _____

- ☐ OK to leave message with detailed information on: HOME / WORK / CELL / OTHER
- ☐ Leave message with call back number only: HOME / WORK / CELL / OTHER

The following people are authorized to receive my medical information:

Name:	Phone: ( )	Relationship:
Name:	Phone: ( )	Relationship:
Name:	Phone: ( )	Relationship:

Written Communication

- ☐ OK to mail to home address
- ☐ OK to mail to work/office address
- ☐ OK to email to:_____
- ☐ Home fax: ( )_____ ☐ Work fax: ( )_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply go uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of *PHI* disclosures.

I have received the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand it may become necessary to disclose my protected health information to another entity as part of my medical treatment, payment of my account or other healthcare operations as defined in the *Notice of Privacy Policies*. I consent to such disclosures for these permitted uses to include electronic interchange, telephone, facsimile and mail.

I understand that I may request restrictions regarding the use of my health information or revoke this consent by following the procedures outlined in the Notice of Privacy Policies. However, the office is not required to agree with any restrictions I request and may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
Note Use and disclosure for treatment, payment, and operations (TPO) information may be permitted without prior consent in an emergency.

Patient Name:_____Signature:_____Date:_____

Patient Representative (if patient is a minor): _____Signature:_____ Date:_____

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