

# Valeria Simone, M.D.

## 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 \_\_\_\_\_ Cell phone \_\_\_\_\_  
 ok to leave message with detailed information       ok to leave message with detailed information  
 Leave message with call back number only       Leave message with call back number only

Work Telephone \_\_\_\_\_ Written Communication  
 ok to leave message with detailed information       ok to mail to my home address  
 Leave message with call back number only

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

Person(s) authorized to receive information on you:

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Name of Person	Relationship
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Name of Person	Relationship
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**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.

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Patient Name (Printed)	Date of Birth
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Patient Signature	(Patient or Authorized Representative)	Date
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Witness	Date
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