Patient Name _____DOB_____

PATIENT DISCLOSURE AUTHORIZATION

The HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of home.

PATIENT NAME_____

I wish to be contacted in the following manner (check all that applies):

Phone #_____

- Leave message with detailed information
- Leave message with call-back number only
- Other (please, indicate)_____

Written communications

- Mail to my home address
- Mail to my office address_____
- Fax to this phone _____
- Email_____
- Other (indicate)_____

List the family members other other person, if any, whom I may contact_
Name_____Phone#_____ Email_____
Name_____Phone#_____ Email_____
Name_____Phone#_____ Email_____

Can confidential messages be left on the answering machine or voice mail at your authorized telephone numbers? Yes:_____ No:_____

Additional information: _____
_____
_____

By signing this form, I am consenting to allow Dr. Libus to use and disclose my PHI to carry out treatment, payment and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Libus may decline to provide treatment to me.

_____ _____
Signature of patient/guardian or representative If not patient, relationship to patient

_____ _____
Date Address and phone# of guardian/representative