

Advanced Pain Management

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of personal health information. (PHI) The individual is also provided the right to request confidential communications or that if communications 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)

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> O.K. to mail to my work/ office address |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> Other _____ |

I hereby give Advanced Pain Management staff permission to discuss my medical care, lab results, billing, and medication, with the following individuals:

- Spouse _____
- Son/Daughter _____
- Other _____

ACKNOWLEDGEMENT:

I acknowledge that i have received a copy or reviewed the Privacy Practices for Advanced Pain Management.

If at any time you would like this permission revoked, you will need to contact Advanced Pain Management.

Patient Signature/ Representative _____

Date _____

Print Name/Relationship _____

Birth Date _____