

Patient Record of Disclosures

Please review and sign the following document.

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 individuals office instead of the individual's home.

Patient Record of Disclosures

Notice of Privacy Practices: I acknowledge that I am being given a copy of the Notice of Privacy practices for the office of McCoy Medical Group, at the time I am signing this document.

<input type="checkbox"/> Home/Cell phone: _____	<input type="checkbox"/> Written communication:
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> Ok to mail to my home address
<input type="checkbox"/> Leave message with call back number ONLY	<input type="checkbox"/> Ok to mail my work/office address
<input type="checkbox"/> Work phone: _____	<input type="checkbox"/> Email: _____
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to email detailed information
<input type="checkbox"/> Leave message with call back number ONLY	<input type="checkbox"/> Email stating to call the office ONLY
<input type="checkbox"/> Other: _____	

Yes, you may speak with the following people if they need to be involved in my care:

ANY member of my family

ONLY specific family members listed below:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

NO, do not speak with my family or friends about my care unless I give specific permission as a later date.

Patient Signature: _____

Date: _____