

Patient Name (please print) \_\_\_\_\_

**Drs. Phipps, Levin, Hebeka, & Associates, Ltd.**

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 protected health information 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):

**Oral Communications:**

- Home Telephone # \_\_\_\_\_
- O.K. to leave message with detailed information
  - Leave message with call-back #

- Work Telephone # \_\_\_\_\_
- O.K. to leave message with detailed information
  - Leave message with call-back #

- Cellular Phone # \_\_\_\_\_
- O.K. to leave message with detailed information
  - Leave message with call-back #

**Written communication:**

- O.K. to Mail detailed information to my home address.
- O.K. to Mail detailed information to my work/office address.
- OK to Email detailed information to this email address \_\_\_\_\_
- O.K. to Fax detailed information to this number \_\_\_\_\_
- Other \_\_\_\_\_

**I permit the Practice to discuss my PHI with, and to disclose my PHI to the following individuals:**

- Spouse \_\_\_\_\_
- Adult child(ren) \_\_\_\_\_
- Personal Representative \_\_\_\_\_

- If checked, the following additional instructions apply:**

\_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_