FORT WORTH PODIATRY

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PATIENT RECORD OF DISCLOSURES

HIPAA PRIVACY AUTHORIZATION FORM

In general, the **HIPAA** privacy rule gives patient the right to request on uses and disclosures of their protected health information (PHI). the patient 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. this information will remain in effect until revoked in writing.

I Wish To Be Contacted In The Following Manner (Check All That Apply):

Home Telephone

- ☐ O.K. to leave message with detailed information
- ☐ Leave name/doctor with call back information only

Work Telephone

- ☐ Leave detailed message on work voicemail
- ☐ Leave name/doctor with call back information only

- ☐ When unable to contact me by phone, a written communication may be set to my home address
- ☐ Other _____

I consent and authorize the release of any NORMAL test results to the following:

- Home Voicemail _____
- Work Vociemail _____
- Cell Voicemail _____
- Spouse _____
- Child(ren) _____
- Parent(s) _____
- Other _____

I consent and authorize the release of any ABNORMAL test results to the following:

- Home Voicemail _____
- Work Vociemail _____
- Cell Voicemail _____
- Spouse _____
- Child(ren) _____
- Parent(s) _____
- Other _____

I understand that by granting this Release, the person who obtains this information may disclose it to other individuals with or without my consent and in so doing the information would no longer be protected under HIPAA.

_____ _____

Print name Date of Birth

_____ _____

Patient's Signature Date

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.