PATIENT FOCUSED
NEUROLOGY

"Patient Care is Our FOCUS."

PATIENT PREFERENCE FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

Patient's Last Name _____ **First** _____ **DOB:** _____

The HIPAA privacy law gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means.

Please read and mark those forms of communications listed below that you personally approve for disclosure and discussion of protected health information. Please put a checkmark on all the contact boxes with your preferences.

Communication with person(s) other than the patient:

Is there a power of attorney? ☐ **Yes** ☐ **No** (If yes, please provide us a copy)

May we discuss your condition with anybody else? ☐ **Yes** ☐ **No** *(If yes, please list the names and relationship to you.)*

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

PATIENT CONTACT INFORMATION

Home Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Cell Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Work Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Please list any other phone numbers we can call: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

If you would like your medical information to be faxed or emailed to you when requested in the future, please provide us your fax number and/or a valid email address. If no fax number and/or email address provided, then you'll have to sign a separate release form in the future in order for us to send your medical information to you via fax and email.

Unless otherwise revoked, or an alternative expiration date is provided here, _____ (indicate date here, maximum 3 YEARS) this authorization is valid for only ONE YEAR from the date listed below. Initials: _____

Written Communication:
May we send mail to my home address? _____ ☐ Yes ☐ No
May we mail to my work/office address? _____ ☐ Yes ☐ No
May we send mail to my email address? _____ ☐ Yes ☐ No
May we send a fax to this number? _____ ☐ Yes ☐ No

*I grant permission to **Patient Focused Neurology** to relay, leave message, fax and/or email me with detailed information regarding my personal health information with the person(s) and contact number(s) and information listed above.*

Patient Name _____ **Signature** X_____ **Date** _____