

## PATIENT RECORD OF DISCLOSURES

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

**Note: Uses and disclosures for TPO( treatment, payment or healthcare operations) may be permitted without prior consent in an emergency.**

Occasionally we will have requests from other facilities for your prescription. If you would like to pre-authorize this service please sign below:

\_\_\_\_\_  
Patient Signature

### Record of Disclosures of Protected Health Information

Date	Disclosed to add/fax	(1)	Description/Purpose	By Whom	(2)	(3)

(1)check if authorized(2)Type: **T**=Treatment **P**=Payment **O**=Healthcare Operations(Ins.)(3) **f**=fax **p**=phone **e**=email  
**m**=mail **o**=other

I have read and acknowledge PSM, Inc. Notice of Privacy Practices. I have asked any questions that I may have. I understand that I may request a copy for my records.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature