

MERCY MEDICAL ASSOCIATES

HIPAA - PATIENT RECORD OF DISCLOSURE FORM

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):

- Home/ Cell Telephone Home / Cell Number
Work Telephone Work Number
Written Communication
Mail to my home address
Mail to my work address
Email address

Patient/ Parent Signature Date

Print Name Birth date of patient

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the requests for PHI to the minimum necessary to accomplish the intended purpose.

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 may be permitted without prior consent in an emergency.

The following names listed are those that I give Mercy Medical Associates the authorization to give health information regarding blood work, appointments, and test results to:

- Relationship
Relationship
Relationship
Relationship

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 7/08)

Signature of Patient/Legal Guardian Date

(To be completed if patient refuses to sign acknowledgement)
Date Name of person providing notice

