Nephrology & Hypertension MEDICAL ASSOCIATES

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner: *(check all that apply)*

- ▢ **Work Telephone**
  - ▢ OK to leave detailed message
  - ▢ Leave message with call back number only
- ▢ **Home Telephone**
  - ▢ OK to leave detailed message
  - ▢ Leave message with call back number only
- ▢ **Written Communication**
  - ▢ OK to mail to home address
  - ▢ OK to mail to work/office
  - ▢ OK to fax to this telephone number_____

You may leave messages with, discuss my treatment, appointments or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Nephrology & Hypertension Medical Associates will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

Please print:

1._____ 3._____

4._____

2._____ 5._____

Patient Signature:_____Date:_____

Please print name:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the Notice of Privacy Practices for Nephrology & Hypertension Medical Associates detailing how my information may be used and disclosed as permitted under federal and state law.

Patient/Guardian Signed_____ Date:_____

Relation to patient:_____

For Office Use Only:

If patient or guardian refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign here:

*Presented by:*_____*(employee name and title)*

Date:_____Time:_____