Patient Record of Disclosures - HIPAA

In general, the Health Insurance Portability and Accountability Act (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 communication, or communication of PHI, 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

1st Phone _____ Cell Home Work

_____ Please leave message with detailed information

_____ Leave message with call-back number only

2nd Phone _____ Cell Home Work

_____ Please leave message with detailed information

_____ Leave message with call-back number only

Email _____ Follow My Health Patient Portal: Yes No

Preferred Method of Contact: Patient Portal Phone US Mail

Emergency Contact: Who we contact in an emergency

Name: _____

Relationship: _____

Birth Date: _____

Phone: _____

Information Release: Who we can discuss your medical information with

Name: _____

Relationship: _____

Birth Date: _____

Phone: _____

Acknowledgment:

I acknowledge I have received, reviewed and understand the **Privacy Practices** and **Financial Policies** for Bayside Family & Sports Medicine

_____

Patient or Personal Representative **Signature** Date

_____

Print name of Patient Birth Date of Patient

Relationship to Patient: (Please circle one) Self Spouse Child Parent/Legal Guardian

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Office use only

In the event the patient refuses to sign this acknowledgment, document the good faith effort to obtain the acknowledgment and the reason the acknowledgement was not obtained.