Patient Record of Disclosures - HIPAA

Patient: _____ **Patient Birth Date:** _____

My Phone Number Is: _____ Cell Home Work

My Second Number Is: _____ Cell Home Work

Yes No Leave message with detailed information

-OR-

Yes No Leave call-back number ONLY

My Email Is: _____

Yes No Joined Sign me up for Follow My Health Patient Portal. CIRCLE ONE

If your portal is active, all non-urgent communication will occur through your Follow My Health Patient Portal.

Bayside May Discuss My Detailed Medical Information With:

Name: _____

Relationship: _____ Birth Date: _____

Phone: _____

Is this same person your Emergency Contact as well? Yes No

If No, who: _____ Phone: _____

Lab Selection: (Please select 1)

- ❑ I prefer to have my labs drawn at Bayside, send my labs to: Quest or McLaren (Circle One)
- ❑ To have my labs drawn, I prefer to go to the Quest Labs
- ❑ To have my labs drawn, I prefer to go to a McLaren Draw Station / McLaren Hospital
- ❑ To have my labs drawn, I prefer to go to _____

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.

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

_____

Patient or Personal Representative Signature **Today's Date**

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